



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Financial Efficiency
Inspection of the VA
Philadelphia Healthcare
System



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Executive Summary

The VA Office of Inspector General (OIG) conducted this inspection to assess the stewardship and oversight of funds by the VA Philadelphia Healthcare System and to identify potential cost efficiencies.¹ To accomplish this goal, the OIG identified and examined financial activities that are under the healthcare system's control and can be compared to other similar facilities within VA healthcare systems.

This inspection assessed the following four financial activities and administrative processes to determine whether the healthcare system had appropriate controls and oversight in place:

- I. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services.² Open obligations include those obligations that are not considered closed or complete and have an unliquidated balance associated with them, whether undelivered or unpaid.³ The inspection team evaluated whether the healthcare system performed monthly reviews, reconciliations of sampled obligations, and identification of excess funds for the timely closing of obligations. Open obligations should be reviewed by the healthcare system finance office to ensure that beginning and ending dates are accurate; open balances are accurate and agree with source documents, such as contracts and purchase orders, receiving reports, invoices, and payments; and obligations beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open.⁴ Any excess funds should be identified promptly and deobligated.
- II. **Purchase card use and oversight.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Documenting transactions as required helps VA and other oversight authorities identify potential fraud, waste, and abuse. Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive

¹ The VA Philadelphia Health Care System operates community-based outpatient clinics in Philadelphia and Horsham, Pennsylvania, and Burlington, Gloucester County, and Camden, New Jersey. The healthcare system is also affiliated with the Perelman School of Medicine at the University of Pennsylvania and is home to several National Research Centers of Excellence. For more information about the healthcare system budget, capacity, and daily census, see appendix A.

² VA Financial Policy, "Obligations Policy," in vol. 2, *Appropriations, Funds, and Related Information*, chap. 5, September 2021 and April 2022.

³ The term "unliquidated obligation" means an obligation incurred by a nonfederal entity that has not been paid (liquidated) or for which the expenditure has not been recorded. 2 C.F.R. § 200.1 (2021).

⁴ VA Financial Policy, "Obligations Policy."

pricing. The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures, and focused on the consideration of contracts for commonly purchased products, known as strategic sourcing, to provide optimal savings to VA.

- III. **Inventory and supply management.** Supply chain management is the integration and alignment of people, processes, and systems to manage all product and service planning, sourcing, purchasing, delivering, receiving, and disposal activities. Veterans Health Administration policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to deliver high-quality care to veterans.⁵ The inspection team evaluated whether the healthcare system met performance metrics for days of stock on hand and complied with policies and procedures for supply chain management. The days-of-stock-on-hand metric promotes inventory level efficiency for items purchased through both the Medical Surgical Prime Vendor (MSPV) program and by other means. To evaluate supply chain management oversight, the team assessed data validity, identified factors that affected the healthcare system's supply chain management, and reviewed quarterly physical inventories.
- IV. **Pharmacy operations.** An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked, analyzing available reports and data, such as inventory turnover rates. Proper inventory management helps ensure that the system makes efficient use of financial resources and has inventory when needed. The team evaluated whether the healthcare system complied with applicable policies and used cost and performance data to track progress toward goals developed by the national Pharmacy Benefits Management office, improved pharmacy program operations, and identified and corrected problems.

The inspection team performed a site visit at the VA Philadelphia Healthcare System during the week of October 3, 2022; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency. For more information about the healthcare system, see appendix A. For more information about the inspection's scope and methodology, see appendixes B and C. The findings and recommendations in this report should help the healthcare system identify opportunities for improvement and greater financial efficiencies.

⁵ VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

What the Inspection Found

The team identified several opportunities for improvement in the areas inspected:

- I. **Open obligations oversight.** The inspection team analyzed data from February through July 2022 and judgmentally selected 20 open obligations that had been inactive for more than 90 days, totaling almost \$6.9 million. The team examined whether the healthcare system finance office reviewed to see if remaining funds associated with each obligation were valid and necessary, as required. The team found that 10 obligations were still within the performance period, and the remaining 10 were more than 90 days past the end date. The healthcare system’s review of open obligations is divided among several finance office personnel based on the nature of the obligation. The team verified that a review was completed on all 20 inactive obligations sampled, in accordance with policy.⁶

The team reviewed VA’s reconciliation reports between the Financial Management System (FMS) and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) and determined that the reports reflected accurate order amounts for the 10 sampled obligations. However, six of the 10 obligations had residual funds totaling about \$44,500 that should have been promptly deobligated.⁷

- II. **Purchase card use and oversight.** The team reviewed a statistical sample of 40 purchase card transactions from October 1, 2021, through July 31, 2022, to determine whether they were processed in accordance with VA policy.⁸ Based on the results of the review, the OIG estimated the healthcare system may have made noncompliance errors in approximately 18,500 purchase card transactions, totaling approximately \$16 million in

⁶ VA Financial Policy, “Obligations Policy.”

⁷ “FMS to IFCAP Reconciliation Report,” (website), VHA, accessed July 16, 2022, <https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=59> (this website is not publicly accessible). See appendix D for more information about better use of funds.

⁸ VA Financial Policy, “Government Purchase Card for Micro-Purchases,” in vol. 16, *Charge Card Programs*, chap. 1B, July 2021 and May 2022. The inspection team reviewed a statistical sample of 40 purchase card transactions from a population of approximately 44,400 purchase card transactions totaling about \$37.6 million from October 1, 2021, through July 31, 2022. At the time of the review, purchase card data was not available for August 1, 2022, through September 30, 2022. See appendix C for further details.

questioned costs.⁹ Also, the team found that the healthcare system spent approximately \$4.2 million in the open market and may have potentially missed cost savings on frequently used goods.

The OIG found that 15 of the 40 transactions were missing some required supporting documentation and projected that cardholders may not have sufficient supporting documentation for just over 18,200 transactions, which corresponds to approximately \$15.6 million in questioned costs. The OIG determined the healthcare system has not implemented a consistent method for electronically storing purchase card documentation, and approving officials did not ensure cardholders retained sufficient documentation to support purchase card transactions as required by VA policy.¹⁰

Of the sampled purchase card transactions, seven did not meet prior approval or separation of duties requirements in VA policy because approving officials did not provide sufficient oversight over the transaction process.¹¹ All sampled transactions met the reconciliation requirement. The team identified potential split purchases for five of the 23 sampled transactions and estimated cardholders may have split purchases and made unauthorized commitments for at least \$106,000 in questioned costs.¹²

The team also assessed whether cardholders adhered to strategic sourcing guidelines, which ensure VA is obtaining the most competitive prices for goods and services.¹³ The OIG found 21 sampled purchase card transactions were open market purchases from eight merchants. During fiscal year (FY) 2022, the healthcare system made over 1,200 purchases, totaling approximately \$4.2 million, from these eight merchants through the

⁹ Purchase card transactions were reviewed for compliance with (1) policy that requires adequate monitoring, approval, and supporting documentation; (2) processes that prevent split purchases and transactions exceeding the cardholder's authorized single-purchase limit; and (3) strategic sourcing procedures, which VA Financial Policy defines as ensuring employees regularly obtain proper contracts when procuring goods and services on a regular basis. Noncompliance issues were only included once for the purposes of calculating this projection. Consideration was also given for margin of error and median confidence level when projecting questioned costs. For additional information regarding projection totals, see appendix B and tables C.1 and C.2. Questioned cost means a cost that is questioned by the auditor because of an audit finding: (1) which resulted from a violation or possible violation of a statute, regulation, or the terms and conditions of a federal award, including for funds used to match federal funds; (2) where the costs, at the time of the audit, are not supported by adequate documentation; or (3) where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances. (4) Questioned costs are not an improper payment until reviewed and confirmed to be improper as defined in OMB Circular A-123, app. C. 2 C.F.R. § 200.1.

¹⁰ VA Financial Policy, "Government Purchase Card for Micro-Purchases." See appendix D for more information about questioned costs.

¹¹ VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be segregated. An agency or organization program coordinator cannot be a cardholder or an approving official. No one person may order, receive, certify funds, and approve his or her own purchase card purchase.

¹² Unauthorized commitments can occur when a purchase, including a split order, is made by a purchase cardholder or contractor who lacks the authority to bind the government or who exceeds his or her delegated authority.

¹³ VA Financial Policy, "Government Purchase Card for Micro Purchases."

open market instead of establishing contracts that could have resulted in negotiated prices and potential cost savings. Generally, the improper reliance on open market purchases appeared to persist because approving officials and cardholders did not always work together to pursue strategic sourcing.

The healthcare system maintained a VA Form 0242, which delegates authority to an individual to use a VA purchase card, for each cardholder in the review sample. The OIG also found the purchase card coordinator conducted internal purchase card reviews during FY 2022, as required by policy, and found similar issues as identified in this OIG inspection, such as missing support documentation, lack of prior approvals, and repetitive open market purchases.¹⁴

III. Inventory and supply management. The healthcare system could improve the efficiency of inventory management by ensuring stock levels and inventory values are recorded correctly in the Generic Inventory Package system, establishing local processes and procedures for monitoring inventory reports, implementing a plan for staff training to increase awareness of internal controls and data reliability in the inventory system, and taking appropriate steps to ensure all supply chain performance measures are maintained in compliance with VA policy.

Leadership vacancies may have affected the healthcare system's management of inventory and supplies. The healthcare system reported having four different logistics chiefs from March 2021 to September 2022. Lack of consistent leadership may have affected continuity in oversight processes and procedures. Staffing shortages were also reported and may have affected the healthcare system's management of inventory and supplies.

The inspection team also assessed oversight of required quarterly physical inventory of "A" classified items, those with the highest 80 percent of annual usage dollars.¹⁵ The OIG found that although physical inventories were completed, accompanying memoranda documenting an inventory count were not consistently signed by the chief supply chain officer, which is required by Veterans Health Administration (VHA) policy.¹⁶ Additionally, not all required Veterans Integrated Service Network (VISN) personnel

¹⁴ VA Financial Policy, "Government Purchase Card for Micro Purchases."

¹⁵ In the ABC classification method, inventory point items with the highest 80 percent of the inventory annual usage dollars are classified as "A." Items with the next highest 10 percent of inventory annual usage dollars are classified as "B." Lastly, items representing the remaining 10 percent of inventory annual usage dollars are classified as "C." The formula for calculating the annual usage dollars of an item is the annual usage quantity multiplied by the average unit price. Only clinical items (versus nonclinical inventories) were assessed for this inspection.

¹⁶ VHA Directive 1761.

were informed upon completion of the physical inventory.¹⁷ The chief supply chain officer is responsible for ensuring compliance with the routing and signing of completed “A” classified physical inventories, but evidence provided to the inspection team detailed he did not do so.

Though the healthcare system maintained a facility inventory master file edit access list and had a process to review access to the inventory system, the inspection team was not provided documentation to support that the chief supply chain officer reviewed the list. VHA policy states that the chief supply chain officer must maintain and review the list each calendar year.

Expendable supplies purchased through the MSPV program should have 15 days or fewer of stock on hand, whereas non-MSPV items should have 30 days or fewer of stock on hand.¹⁸ During the inspection period, the healthcare system averaged 30 days of stock on hand for MSPV items and 59 days of stock on hand for non-MSPV items. Because of the COVID-19 pandemic, the healthcare system received a waiver to suspend days-of-stock-on-hand performance measures from May 7, 2020, through March 31, 2022, and order accordingly to avoid potential shortfalls. Staffing levels, training issues, oversight, and data integrity and validity issues also affected the stock levels.

IV. Pharmacy operations. The healthcare system could improve pharmacy efficiency by narrowing the gap between observed and expected drug costs, avoiding end-of-year purchases, and meeting requirements for monthly B09 reconciliation reporting.¹⁹ Using a VA efficiency rating system, the inspection team found that the VA Philadelphia Healthcare System had a gap of approximately \$17.6 million between the facility’s observed and expected drug costs. According to the VHA’s Office of Productivity, Efficiency, and Staffing (OPES) model (based on FY 2021 data), the healthcare system spent approximately \$87.8 million in observed prescription drug costs compared to about \$70.3 million in expected drug costs during the inspection period.²⁰

¹⁷ VHA divides the United States into 18 Veterans Integrated Service Networks, regional systems that work together to meet local healthcare needs and provide greater access to care.

¹⁸ The national MSPV program provides a customized distribution system to meet or exceed facility requirements through a just-in-time distribution catalog ordering process.

¹⁹ The B09 reconciliation process is how VA medical center pharmacies review what is ordered against what is received to ensure they are making correct payments for the drugs they receive.

²⁰ “VHA OPES Efficiency Opportunity Grid FY 2022 (based on 2021 data)” (website), OPES, accessed August 16, 2022, <https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx> (this website is not publicly accessible). The OPES pharmacy expenditure model uses the terms “observed minus expected” and “potential opportunity” to describe the gap between a facility’s actual drug costs and expected drug costs. This difference represents the amount associated with potential efficiency improvements. An observed-minus-expected ratio above 1.0 indicates that a facility may have opportunities to reduce its pharmacy costs.

The inspection team looked for abnormal order quantities during the review period and noted that the purchase of intravenous solution with electrolytes increased by about \$14.5 million, from about \$2.7 million in FY 2020 to about \$17.2 million during FY 2021, an increase of about 545 percent. Pharmacy personnel reported that due to staff shortages and high turnover, the pharmacy staff lacked the facility-specific knowledge and experience to utilize and explain the OPES variance. Additionally, the team identified that a lack of consistent leadership may have affected the ability for staff to receive and resolve error alerts in a timely manner.

The facility's turnover rate for pharmacy inventory, an efficiency measure, was inconsistent with meeting the national inventory turnover target rates, as established by the national Pharmacy Benefits Management office. In addition, the team identified that pharmacy staff were not implementing inventory management practices, such as placing bar codes on stock at all locations, using handheld barcode readers, and consistently adhering to the established ABC inventory turnover rates. The OIG also found that healthcare system officials did not submit B09 monthly reconciliation packages to the fiscal office and said they were not aware of this noncompliance with VA policy.

What the OIG Recommended

The OIG made 12 recommendations to the healthcare system director. The findings and recommendations provide healthcare system leaders opportunities for process improvement, encourage greater cost efficiencies, and promote the responsible use of VA's appropriated funds.

The OIG recommended that the healthcare system director (1) ensure finance office staff are made aware of policy requirements, reviews are conducted on all inactive open obligations, and any identified excess funds are deobligated.²¹

To strengthen purchase card transactions, the director should (2) ensure cardholders comply with record retention policy requirements and (3) establish controls to confirm approving officials and purchase cardholders review purchases properly and make sure contracting is used when it is in the best interest of the government. In addition, purchase cardholders should (4) request approval for any unauthorized commitments identified.²²

Related to inventory and supply management, the OIG recommended the director (5) establish local processes and procedures to ensure all necessary inventory reports are routinely monitored to ensure performance measures are maintained; (6) initiate and provide training on local supply chain procedures and processes, and for data within the Generic Inventory Package system;

²¹ VA Financial Policy, "Obligations Policy."

²² VA Financial Policy, "Government Purchase Card for Micro-Purchases."

(7) ensure compliance with the physical inventory of “A” classified items; and (8) ensure compliance with the annual review of the facility item master file edit access list.

The OIG made four recommendations regarding pharmacy operations, including (9) developing and implementing a plan to achieve identified efficiency targets using available pharmacy data to make business decisions, as well as (10) establishing measures that avoid end-of-year purchasing. The OIG also recommended that the facility (11) align inventory management practices with use of scanners, barcoding, and ABC inventory analysis and (12) establish processes to ensure compliance for the completion of monthly B09 reconciliations.

VA Comments and OIG Response

The VA Philadelphia Healthcare System director concurred with recommendations 1–12 and provided responsive corrective action plans for each recommendation. Appendix E includes the healthcare system director’s comments.

The OIG considers all recommendations open. While the director of the healthcare system reported that corrective actions for some of the recommendations were already completed, the OIG has not received any evidence or supporting documentation that would allow the evaluation of these actions. The OIG will monitor the implementation of all planned actions and will close the recommendations when the VA Philadelphia Healthcare System provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.



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Abbreviations

FMS	Financial Management System
FTE	full-time equivalent
FY	fiscal year
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System
MSPV	Medical Surgical Prime Vendor
OIG	Office of Inspector General
OPES	Office of Productivity, Efficiency, and Staffing
PBM	Pharmacy Benefits Management
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency inspections to assess stewardship and oversight of funds at VA healthcare systems and to identify opportunities to achieve cost efficiencies. Inspection teams identify and examine financial activities that are under the healthcare system’s control and can be compared to healthcare systems similar in size and complexity across VA to promote best practices.²³

This inspection focused on the VA Philadelphia Healthcare System. The OIG assessed the following financial activities and administrative processes to determine whether appropriate controls and oversight were in place from October 2021 through September 2022:

- I. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services.²⁴ Open obligations include those obligations that are not considered closed or complete and have a balance associated with them, whether undelivered or unpaid. The inspection team evaluated whether the healthcare system performed monthly reviews, reconciliations of sampled obligations, and identification of excess funds for the timely closing of obligations. Open obligations should be reviewed by the healthcare system finance office to ensure that beginning and ending dates are accurate; open balances are accurate and agree with source documents, such as contracts and purchase orders, receiving reports, invoices, and payments; and obligations beyond 90 days of the period of performance end date or without activity in the past 90 days are determined by the healthcare system finance office to be valid and should remain open.²⁵ Any excess funds should be identified promptly and deobligated so they may be used elsewhere.
- II. **Purchase card use and oversight.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Documenting transactions as required helps VA and other oversight authorities identify potential fraud, waste, and abuse. Using contracts for common purchases allows VA to optimize purchasing power and obtain competitive pricing. The team examined whether the healthcare system’s purchase card program ensured compliance with policies and

²³ The Veterans Health Administration (VHA) uses a facility complexity model that classifies its facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. The VA Philadelphia Health Care System was rated as a level 1b, high-complexity facility.

²⁴ VA Financial Policy, “Obligations Policy,” in vol. 2, *Appropriations, Funds, and Related Information*, chap. 5, September 2021 and April 2022.

²⁵ VA Financial Policy, “Obligations Policy.”

procedures, and focused on the consideration of contracts for commonly purchased products, known as strategic sourcing, to provide optimal savings to VA.

- III. **Inventory and supply management.** Supply chain management is the integration and alignment of people, processes, and systems to manage all product and service planning, sourcing, purchasing, delivering, receiving, and disposal activities. Veterans Health Administration (VHA) policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to deliver high-quality care to veterans.²⁶ The inspection team evaluated whether the healthcare system met performance metrics for days of stock on hand and complied with policies and procedures for supply chain management. The days-of-stock-on-hand metric promotes inventory level efficiency for items purchased through the Medical Surgical Prime Vendor (MSPV) program and other means. To evaluate supply chain management oversight, the team assessed data validity, identified factors that affected the healthcare system's supply chain management, and reviewed quarterly physical inventories.
- IV. **Pharmacy operations.** An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked, analyzing available reports and data, such as inventory turnover rates. Proper inventory management helps ensure that the system makes efficient use of financial resources and has inventory when needed. The team evaluated whether the healthcare system complied with applicable policies and used cost and performance data to track progress toward goals developed by the national Pharmacy Benefits Management office, improved pharmacy program operations, and identified and corrected problems.

To assess these areas, the inspection team performed a site visit at the VA Philadelphia Healthcare System during the week of October 3, 2022; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial activities. The team selected data from fiscal year (FY) 2022 for the inspection. For more information about the healthcare system, see appendix A. For more information about the inspection's scope and methodology, see appendixes B and C.

VA Philadelphia Healthcare System

The VA Philadelphia Healthcare System, part of Veterans Integrated Service Network (VISN) 4, serves veterans in the city of Philadelphia at the Corporal Michael J. Crescenz VA Medical Center.²⁷ The healthcare system also provides services at seven community-based outpatient

²⁶ VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

²⁷ VHA divides the United States into 18 Veterans Integrated Service Networks, regional systems that work together to meet local healthcare needs and provide greater access to care.

clinic locations in the city of Philadelphia, southeastern Pennsylvania, and southern counties in New Jersey, along with a community living center, and several National Research Centers of Excellence.²⁸ In FY 2022, the VA Philadelphia Healthcare System operated close to 420 hospital beds among its facilities and provided services to approximately 66,000 veteran patients. The reported FY 2022 medical care budget was approximately \$767.6 million, a \$15.3 million increase (2 percent) over the FY 2021 budget of approximately \$752.3 million, which was an increase of almost \$96.7 million (15 percent) from the FY 2020 budget of approximately \$655.6 million. The VA Philadelphia Healthcare System is primarily affiliated with the Perelman School of Medicine at the University of Pennsylvania and offers a wide range of health, support, and facility services.

Facility Selection

The inspection team evaluated VA data to identify healthcare systems with the greatest potential for financial efficiency improvements based on data from the VHA Office of Productivity, Efficiency, and Staffing's (OPES) efficiency opportunity grid. VHA developed the efficiency opportunity grid, a collection of 12 statistical models, to give facility leaders insight into areas of opportunity for improving efficiency. The grid allows for comparisons between VHA facilities by adjusting data for variations in patient and facility characteristics and in geography. The grid also describes possible inefficiencies and areas of success by showing the difference between a facility's actual and expected costs. The team uses the facility rankings from the stochastic frontier analysis model in the grid to select facilities for financial efficiency inspections.²⁹ The inspection, while limited in scope and not intended to be a comprehensive inspection of all financial operations at the VA Philadelphia Healthcare System, sets forth a goal to recommend opportunities for process improvement, greater efficiencies, and to promote the responsible use of appropriated funds.

²⁸ The VA Philadelphia Health Care System operates community-based outpatient clinics at several locations in Philadelphia, Horsham, Pennsylvania, as well as Burlington, Gloucester County, and Camden, New Jersey. For more information about the healthcare system budget, capacity, and daily census, see appendix A.

²⁹ Stochastic frontier analysis is a modeling principle to estimate the optimal or minimum cost (input) after controlling for risks and random factors for each VA medical center given a set of outputs and output characteristics. Based on the minimum cost, an efficiency score is derived for each facility; an efficiency score of one is most efficient, and values greater than one are associated with increasing inefficiency.

Results and Recommendations

I. Open Obligations Oversight

VA's management of open obligations has been a long-standing issue and was included as a significant deficiency in VA's FY 2022 and FY 2021 audited financial statements and as a material weakness in VA's FY 2020 audited financial statements.³⁰ Additionally, a 2019 OIG report on undelivered orders recommended VHA ensure that staff review and reconcile open orders, identify and deobligate excess funds on those orders, and follow VA policy regarding required reviews of open obligations.³¹ If reviews are not conducted, the facility is vulnerable to the risk that those funds cannot be used for other goods or services in that fiscal year to support veterans.

The inspection team focused on the following areas related to open obligations:

- **Inactive obligations.** The inspection team assessed whether the healthcare system performed monthly reviews and reconciliations to ensure that the sampled inactive obligations were valid and should remain open. Inactive obligations are those obligations that have had no activity for more than 90 days.
- **Financial Management System (FMS) to Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) reconciliations.** The team identified open obligations with different end dates or order amounts between FMS and IFCAP to ensure the healthcare system reconciled end dates and order amounts between the systems for the sampled obligations.

Finding 1: Funds from Inactive Obligations Were Not Promptly Deobligated

The OIG found the healthcare system could improve management of open obligations by closing purchase orders and obligations after the initiating service has confirmed acceptance of all goods or services and all invoices have been received and paid. Failure to properly manage open

³⁰ VA OIG, [Audit of VA's Financial Statements for Fiscal Years 2022 and 2021](#), Report No. 22-01155-14, November 15, 2022; VA OIG, [Audit of VA's Financial Statements for Fiscal Years 2021 and 2020](#), Report No. 21-01052-33, November 15, 2021; VA OIG, [Audit of VA's Financial Statements for Fiscal Years 2020 and 2019](#), Report No. 20-01408-19, November 24, 2020. CliftonLarsonAllen LLP defines a material weakness as "a deficiency, or combination of deficiencies, in internal control over financial reporting such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis." A significant deficiency is "a deficiency, or a combination of deficiencies, in internal control over financial reporting that is less severe than a material weakness, yet important enough to merit attention by those charged with governance."

³¹ VA OIG, [Insufficient Oversight of VA's Undelivered Orders](#), Report No. 17-04859-196, December 16, 2019. All recommendations from this report have been implemented and closed.

obligations increases the risk of not spending appropriations within the correct fiscal year and potentially leaving funds attached to orders when they could be used for other purposes to benefit veterans.

VA policy requires finance offices to perform monthly reviews and reconciliations of obligations that are open more than 90 days past the period of performance end date or have been inactive for more than 90 days to ensure the obligation is still valid and funds are expended appropriately.³² For these obligations, healthcare system finance office personnel should verify with the initiating service or contracting officer, if applicable, that the goods or services have not been received and are still needed. The responsible finance office should also review data from VA's FMS against supporting documentation on a monthly basis to ensure reports, subsidiary records, and systems reflect proper costing, an accurate delivery date and end date, and a correctly calculated unliquidated balance.³³ If funds remain obligated after the goods or services have been delivered, the initiating service has confirmed acceptance, and invoices have been received and paid, the acquisition office will modify the contract or order to reflect the final cost and decrease the remaining funds on the obligation.

³² VA Financial Policy, "Obligations Policy."

³³ 2 C.F.R. § 200.1 (2021). The term "unliquidated obligation" means an obligation incurred by a nonfederal entity that has not been paid (liquidated) or for which the expenditure has not been recorded.

Figure 1 shows the number and dollar amounts of inactive obligations for the VA Philadelphia Healthcare System from February through July 2022.

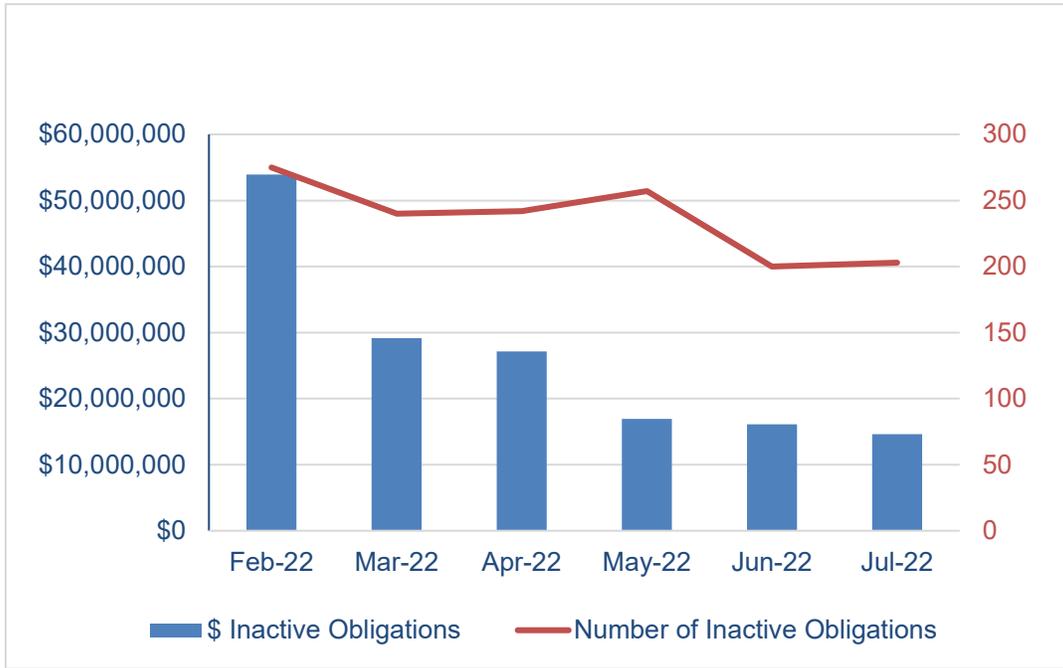


Figure 1. VA OIG analysis of inactive obligations for the VA Philadelphia Healthcare System, February through July 2022.

Source: VA FMS F850 Report.

As of July 31, 2022, the healthcare system had 203 inactive obligations totaling \$14.6 million. Figure 2 shows the age and dollar amounts of the 203 obligations. As shown, 121 obligations totaling over \$9.8 million had no activity for at least 181 days.

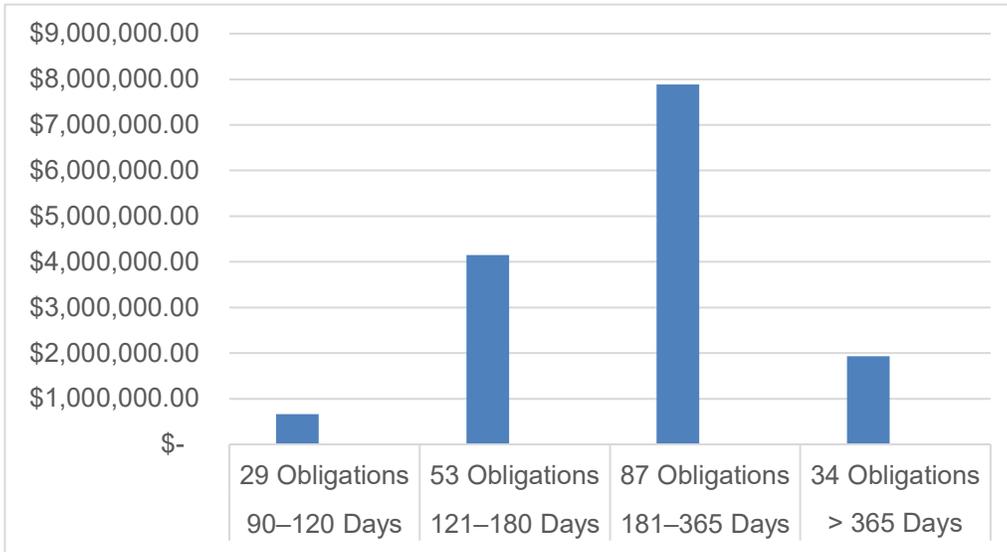


Figure 2. VA OIG analysis of inactive obligations for the VA Philadelphia Healthcare System in July 2022.

Source: VA FMS F850 Report.

Inactive Obligations

The inspection team performed data analysis and selected 20 inactive obligations open as of July 31, 2022, totaling almost \$6.9 million. The team reviewed supporting documentation to assess whether the healthcare system identified and reviewed the sampled obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy.³⁴ Ten obligations were still within the performance period, and the remaining 10 were more than 90 days past the performance period end date. The team was able to verify that monthly reviews were completed on each of the 20 selected obligations, which were found to be still valid and needed to remain open. See appendix B for additional details on the inspection’s scope and methodology and appendix C for details on the inspection’s sampling.

VA financial policy states open obligations should be reviewed by the finance office, in coordination with the initiating service, to ensure that obligations aged beyond 90 days of the period of performance end date or without activity in the previous 90 days are valid and should remain open. An accounting technician stated that reviews are divided among several personnel in the healthcare system finance office, depending on the specific type of obligation, and start once an obligation has been inactive for 61 days. The chief accountant reported reviews for

³⁴ VA Financial Policy, “Obligations Policy.”

obligations inactive beyond 90 days are also conducted and that overall efforts by accounting staff to reduce the number of open obligations resulted from an increased emphasis by VISN leaders. The team concluded that sampled obligations had been reviewed in accordance with policy, therefore the OIG made no recommendations related to the review of inactive obligations.

End-Date and Order Amount Discrepancies between FMS and IFCAP Reconciliations

IFCAP handles the processing of certified invoices and electronic transmission of receiving documents to FMS. In addition, IFCAP transfers obligation information back to the control point and updates the control point balance automatically.³⁵ The end dates in both systems should be the same. However, staff can manually change end dates in one system without changing them in the other. Open obligations should be reviewed monthly by the healthcare facility's finance office, in coordination with the initiating service, to ensure period of performance dates are correct and match in all systems.³⁶

The inspection team reviewed FMS to IFCAP reconciliation reports for the period of February through July 2022 for end-date and order amount discrepancies. The team identified 16 open obligations with end-date discrepancies between FMS and IFCAP for three or more months. Healthcare system officials reported they had focused on order amount differences between FMS and IFCAP instead of end-date differences. As a result of the inspection, the chief accountant said finance office staff began using the FMS to IFCAP reconciliation report to compare end dates and work on reconciling them among the systems.

The inspection team identified 52 additional open obligations with order amount discrepancies between FMS and IFCAP for three or more months. To determine if order amounts were accurate and reconciled between the two systems, the team selected and evaluated 10 of these open obligations with order amount discrepancies totaling about \$1.4 million from the FMS to IFCAP reconciliation reports.³⁷ The discrepancies were due to timing issues of amounts posting between both systems, and modified order amounts would also cause discrepancies if these modifications were not posted in a timely manner. The team determined that FMS and IFCAP were corrected by the healthcare system before the inspection and reflected correct order amounts for all 10 obligations reviewed. During the review of order amounts, the team identified

³⁵ A control point is a financial element used to permit the tracking of money from an appropriation or fund to a specified service, activity, or purpose.

³⁶ VA Financial Policy, "Obligations Policy."

³⁷ "FMS to IFCAP Reconciliation Reports" (website), VHA, accessed July 16, 2022, <https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=59> (this website is not publicly accessible).

six obligations that had residual funds totaling approximately \$44,500 that should have been deobligated in a timely manner after the goods were received.

For the six obligations, the healthcare system did not deobligate the residual funds associated with the purchase orders and obligations after the initiating service had confirmed acceptance of all goods or services and all invoices had been received and paid. The acquisition office should modify the contract or order to reflect the final cost and quantity of the goods or services and decrease the remaining funds on the obligation. Contracting staff and service line staff should complete the deobligation in FMS in a timely manner. If the end date has passed and the obligation is no longer valid, those funds should be deobligated and made available for use elsewhere.

Finding 1 Conclusion

Healthcare system personnel should be aware of and comply with all facets of VA policy on open obligations. This includes deobligating funds from purchase orders and obligations after the initiating service has confirmed acceptance of all goods or services and all invoices have been received and paid. Failure to properly manage open obligations increases the risk of failing to spend appropriations within the associated fiscal year and leaving funds attached to orders when they could be used for other purposes to benefit veterans.

Recommendation 1

The OIG made one recommendation to the VA Philadelphia Healthcare System director:

1. Ensure that healthcare system finance office staff are made aware of all VA financial policy requirements in the review and management of inactive open obligations, and deobligate any identified excess funds.

VA Management Comments

The VA Philadelphia Healthcare System director concurred with recommendation 1. The responses to all report recommendations are provided in full in appendix E.

To address recommendation 1, the director reported that there has been a sharp decline in the number of inactive obligations due to the accounting staff putting efforts forward to resolve open undelivered orders. The director also detailed that the obligation tool, providing a standard framework for tracking open financial obligations as well as resolutions for undelivered orders, was renovated in April 2023, with training provided to finance staff and service chiefs. Fiscal staff will continually follow up with the individual services and contracting on all open obligations, and a new internal auditor will be able to ensure comments in the obligations database are populated in a more timely and accurate manner.

OIG Response

The healthcare system director's action plan is responsive to the recommendation. Although the healthcare system director said the recommendation has already been addressed, the OIG received no evidence or supporting documentation to evaluate what was done. The OIG will monitor implementation of the planned actions and will close the recommendation when it receives sufficient evidence demonstrating progress in addressing the intent of the recommendation and the issues identified.

II. Purchase Card Use and Oversight

VA established its Government Purchase Card Program to reduce the administrative costs of acquiring goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. From October 1, 2021, through September 30, 2022, the VA Philadelphia Healthcare System spent approximately \$46.6 million through purchase cards, representing approximately 54,600 transactions. The amount and volume of the healthcare facility's spending through the program make it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.

The team reviewed the following areas:

- **Supporting documentation.** The team examined whether the healthcare system maintained supporting documentation as required for purchases to provide assurance of payment accuracy and to justify the need to purchase a good or service. This includes approved purchase requests, purchase orders, receiving reports, vendor invoices, and, when necessary, written justification for purchases from a third-party payer.³⁸ Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.
- **Purchase card transactions.** The team assessed whether approving officials ensured cardholders obtained prior approvals, conducted prompt reconciliation of transactions, and maintained separation of duties.³⁹ Also, the team reviewed whether the healthcare system processed purchase card transactions in accordance with VA policy, such as whether approving officials prevented split purchases designed to avoid exceeding the single-purchase limit or micropurchase threshold.⁴⁰ Additionally, the team assessed whether the healthcare system considered obtaining contracts when procuring goods and services regularly, which VA refers to as

³⁸ VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs*, chap. 1B, July 2021 and May 2022. Cardholders will not use third-party payers unless there are no other available vendors. Cardholders will justify in writing if a third-party payer is used and keep documentation identifying the actual vendor providing the item. Examples of third-party payers include PayPal, eMoney, E-Account, Amazon Marketplace, Google Checkout, and Venmo.

³⁹ VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be separated. An agency or organization program coordinator cannot be a cardholder or an approving official. No one person may order, receive, certify funds, and approve a purchase card purchase.

⁴⁰ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

“strategic sourcing.”⁴¹ Using contracts reduces open market or individual purchases and enables VA to leverage its purchasing power.

- **Purchase card oversight.** The team assessed whether the purchase card coordinator completed periodic purchase card reviews throughout FY 2022. These reviews ensure systematic controls exist that help reduce errors and ensure a facility complies with VA policy. In addition, the team reviewed VA 0242 forms for each cardholder to determine if they were complete and accurate.⁴²

Finding 2: The Healthcare System Did Not Always Maintain Supporting Documentation or Consider Using Contracts

The OIG found the healthcare system leaders did oversee the purchase card program but could improve efficiency by ensuring consistent supporting documentation among purchase card transactions. In addition, the healthcare system did not ensure proper reviews were conducted by approving officials and cardholders to validate purchases, support strategic sourcing, and prevent split purchases. Failure to properly manage the purchase card program increases the risk of insufficient documentation, improper payments, and missed opportunities to optimize cost savings. Based on the results of the review, the OIG estimated the healthcare system may have made noncompliance errors in approximately 18,500 purchase card transactions, totaling approximately \$16 million in questioned costs.⁴³ The healthcare system should continue to ensure internal reviews are conducted to mitigate the risk of fraud, waste, and abuse.

Supporting Documentation

VA financial policy requires cardholders to upload and electronically store supporting documents for purchase card transactions to a VA-approved document-imaging system. When healthcare system staff buy goods and services, they must maintain supporting documentation, such as approved purchase requests, vendor invoices, purchase orders, and receiving reports, for

⁴¹ VA Financial Policy, “Government Purchase Card for Micro-Purchases.” Strategic sourcing is defined as ensuring employees obtain proper contracts when procuring goods and services regularly.

⁴² An approved VA Form 0242, Governmentwide Purchase Card Certification, is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services.

⁴³ 2 C.F.R. § 200.1 Questioned cost means a cost that is questioned by the auditor because of an audit finding: (1) which resulted from a violation or possible violation of a statute, regulation, or the terms and conditions of a federal award, including for funds used to match federal funds; (2) where the costs, at the time of the audit, are not supported by adequate documentation; or (3) where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances. (4) Questioned costs are not an improper payment until reviewed and confirmed to be improper as defined in OMB Circular A-123, app. C. Noncompliance issues were only included once for the purposes of calculating this projection. Consideration was also given for margin of error and median confidence level when projecting questioned costs. For additional information regarding projection totals, see appendix B and tables C.1 and C.2.

six years.⁴⁴ This documentation verifies that purchase card transactions were properly approved and that payments were accurate.

The inspection team reviewed a statistical sample of 40 transactions to determine whether the VA Philadelphia Healthcare System maintained required purchase card transaction documentation.⁴⁵ The team found that 15 sampled purchase card transactions were missing some required supporting documentation. For example, supporting documentation for seven transactions did not contain an invoice from the vendor. Based on these results, the team estimated cardholders may not have sufficient supporting documentation for just over 18,200 of 44,400 purchase card transactions, or about 41 percent, which resulted in approximately \$15.6 million in questioned costs.⁴⁶ This occurred because approving officials did not always ensure cardholders retained sufficient documentation to support purchase card transactions. In addition, the healthcare system has not implemented a consistent method for electronically storing documentation on the charge card portal or another VA-approved document-imaging system.

Purchase Card Transactions

VA policy requires purchase cardholders to meet three requirements when using government purchase cards to acquire goods and services:

- **Prior approval.** Before initiating a purchase, the cardholder must obtain prior approval for the purchase to ensure a valid business need; the approval may vary in form and content but must be retained as supporting documentation.⁴⁷
- **Reconciliation.** Reconciliation of a purchase should be completed by the cardholder and approved by the approving official no later than the 15th calendar day of the month after the closing of the previous month's billing cycle (accounts not reconciled within 30 days of the due date will have their single-purchase limit lowered).⁴⁸

⁴⁴ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

⁴⁵ The inspection team reviewed a statistical sample of 40 purchase card transactions from a population of approximately 44,400 purchase card transactions totaling about \$37.6 million from October 1, 2021, through July 31, 2022. At the time of the review, purchase card data was not available for August 1, 2022, through September 30, 2022.

⁴⁶ See appendix B for additional details on the scope and methodology and appendix C for details on sampling.

⁴⁷ VA Financial Policy, "Government Purchase Card for Micro-Purchases." Some examples of approval documentation include emails, requisitions, memos, consults, or notes. Regardless of the form, the documentation must contain a certification from the requestor that the proposed purchase is for a legitimate government need, not for personal benefit, as well as a list of all items to be purchased.

⁴⁸ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

- **Separation of duties.** Healthcare facility staff must maintain separation of duties to ensure roles and responsibilities do not overlap among the cardholder, approving official, receiver of purchased items or services, or requesting official to reduce the risk of fraud, waste, and abuse.⁴⁹

The inspection team assessed documentation of the 40 sampled purchase card transactions provided by healthcare system personnel to determine if these requirements were met. While all sampled purchase card transactions met the reconciliation requirement, the OIG found errors in seven transactions regarding the separation of duties and prior approval requirements, including two that did not meet either of them. Of the remaining five deficient transactions, four did not maintain separation of duties and one did not obtain prior approval.⁵⁰

These issues occurred because approving officials did not provide sufficient oversight over the transaction process to ensure cardholders obtained documented purchase approvals before making purchases and obtained receiving documentation that shows who received the purchased items. VA policy requires another VA employee to verify and document goods or services received by the same cardholder who placed the order. Approving officials must ensure transactions are legal, proper, and mission-essential. This includes ensuring that proper approvals are obtained and documented before the purchase and that separation of duties is maintained throughout the transaction process.⁵¹

The inspection team also assessed if cardholders split purchases into two or more acquisitions to circumvent their authorized single-purchase limit. Contracting should be used when the total value of the requirement exceeds the micropurchase threshold or the cardholder's authorized single-purchase limit.⁵² Cardholders must not modify a requirement or order into smaller parts to avoid exceeding their micropurchase threshold, purchase card limit, or the use of formal contracting procedures. The requirement for the goods or services should be communicated to the contracting office for procurement.⁵³

⁴⁹ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

⁵⁰ The inspection team reported actual sample results rather than estimations for these transactions because of the low sample size and low error count; the estimation also had poor precision due to the low numbers and high variability in sample weights.

⁵¹ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

⁵² VHA executive director of the Office of Acquisition and Logistics and senior procurement executive, "Emergency Acquisition Flexibilities—Emergency Assistance Activities in support of Global Pandemic for Coronavirus Disease 2019 (COVID-19)," memorandum to VA heads of contracting activities, March 15, 2020. This memo increased the micropurchase threshold to \$20,000 for goods and services purchased in the United States due to the COVID-19 pandemic and has not been rescinded. As of May 2022, all VA purchase card accounts previously set at \$20,000 have been reduced to \$10,000.

⁵³ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

The team assessed 23 sampled purchase card transactions to determine if cardholders split purchases.⁵⁴ After reviewing documentation and interviewing a purchase cardholder, approving official, and purchase card coordinator, the team determined five transactions were split purchases. As a result, the team estimated that cardholders may have split purchases and made unauthorized commitments for at least \$106,000 in questioned costs.⁵⁵

Example 1 illustrates a sampled transaction identified as a split purchase and unauthorized commitment.

Example 1

On October 14, 2021, a cardholder placed three separate orders of prescription drugs with the same vendor, two orders costing \$6,548.15 each and a third order costing \$7,857.78, for a total of \$20,954.08. All three orders were shipped on different dates, but the cardholder was charged for all purchases on November 16, 2021. Although the purchases were for three separate patients in the VA Philadelphia Healthcare System, the total need and cost were known at the time of the purchase to exceed the cardholder's authorized single-purchase limit of \$10,000. These transactions represent a split purchase.

The split purchases occurred because approving officials did not always provide sufficient oversight during the transaction process to ensure cardholders communicated with the contracting office to determine if alternative contracting options were warranted or available. The proper way to purchase frequently needed or high-cost goods above the purchase card limit is to send the service request to the contracting office for purchase. This requires planning to ensure there is sufficient time for a contract to be expanded, or established if none exists, to purchase the products in time for scheduled use. Any VA purchase cardholder or approving official who makes or certifies a purchase exceeding the micropurchase threshold has created an unauthorized commitment that must be ratified.⁵⁶

Strategic Sourcing

The inspection team also assessed the 40 sampled transactions for evidence that healthcare system staff had considered the most appropriate purchasing mechanism. In accordance with policy, VA cardholders should pursue strategic sourcing—establishing contracts that generally

⁵⁴ VA Financial Policy, “Government Purchase Card for Micro-Purchases.” A split purchase occurs when a cardholder intentionally modifies a known single requirement into two or more purchases or payments to avoid exceeding their single purchase limit or the micropurchase threshold.

⁵⁵ Unauthorized commitments can occur when a purchase, including a split order, is made by a purchase cardholder or contractor who lacks the authority to bind the government or who exceeds his or her delegated authority.

⁵⁶ FAR 1.602-3. Ratification means the act of approving an unauthorized commitment by an official who has the authority to do so.

provide greater savings to VA rather than using purchase cards for open market acquisitions without a negotiated price—for goods that are purchased on a recurring or ongoing basis.⁵⁷ Approving officials, the agency or organization program coordinator, and cardholders must review purchases to determine when establishing contracts is in the best interest of the government. Generally, VA should use contracts if the purchase is for an ongoing order of goods or services.

During the review, the team determined 21 sampled purchase card transactions were open market purchases from eight merchants. Further analysis of FY 2022 purchase card data showed that the healthcare system made over 1,200 purchases, totaling approximately \$4.2 million, from these eight merchants. The healthcare system made these purchases through the open market instead of establishing contracts that could have resulted in negotiated prices and potential cost savings. Table 1 shows the eight merchants with total number of transactions and amounts spent for the healthcare system in FY 2022.

Table 1. Eight Merchants with Open Market Purchases from the Philadelphia Healthcare System

Merchants	Amount Spent	Transaction Count
Merchant 1	\$1,543,064	522
Merchant 2	\$995,864	353
Merchant 3	\$861,931	134
Merchant 4	\$373,226	53
Merchant 5	\$175,115	32
Merchant 6	\$144,507	41
Merchant 7	\$44,521	20
Merchant 8	\$32,700	71
Total	\$4,170,928	1,226

Source: VA OIG team assessment of Philadelphia Healthcare System FY 2022 purchase card data.

Generally, the improper reliance on open market purchases appeared to persist at the healthcare system because the approving officials and cardholders did not always work together to ensure they pursued strategic sourcing. Throughout the transaction process, approving officials and cardholders should communicate with the contracting office to establish contracts, and minimize

⁵⁷ VA Financial Policy, “Government Purchase Card for Micro-Purchases.”

open market purchases. To meet the intent of VA policy, cardholders should work with the contracting office to determine if alternative contracting options are warranted or available.⁵⁸

Purchase Card Oversight

Periodic purchase card reviews are intended to evaluate and improve the effectiveness of internal controls and compliance with regulations and policies. VA policy requires the purchase card coordinator and Financial Services Center to conduct reviews to ensure purchases are properly documented and identify potential split purchases, unauthorized commitments, fraud, waste, and abuse.⁵⁹ The purchase card coordinators should also analyze spending patterns and determine whether cardholders are optimizing purchasing power and cost savings by using strategic sourcing techniques. Lastly, reviewers should identify and report any issues and ensure remediation actions are effective.⁶⁰

During the inspection period, the OIG found that the purchase card coordinator did conduct internal purchase card reviews throughout FY 2022. These internal reviews found similar issues as identified in this OIG inspection, such as missing support documentation, lack of prior approvals, and repetitive open market purchases. It is imperative that these internal reviews are consistently completed to help identify purchase card internal control weaknesses and ensure corrective actions are taken by the healthcare system to help mitigate the risk of fraud, waste, and abuse.

Additionally, the OIG found that all 18 cardholders responsible for the sampled purchase card transactions had a VA Form 0242. However, five cardholders' forms were missing the signature or signature date from the agency/organization program coordinator, purchase card coordinator, delegation authority or approving official. Also, one cardholder had an inaccurate spending limit compared to the cardholder's US Bank data. An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to pay for goods and services. This form also establishes purchase limits and responsibilities and is essential for accountability for cardholders and approving officials. A revised form is required when the approving officer changes, cardholders legally change their names, or the single-purchase limit is increased above the originally requested amount.⁶¹

⁵⁸ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

⁵⁹ VA Financial Policy, "Government Purchase Card for Micro-Purchases." The Financial Services Center provides an array of financial management, professional, and administrative services to VA.

⁶⁰ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

⁶¹ VA Financial Policy, "Administrative Actions for Government Purchase Cards," in vol. 16, *Charge Card Programs*, chap. 1A, June 2018.

Finding 2 Conclusion

Healthcare system personnel should be aware of and comply with VA policies on purchase card record retention requirements, split purchases, and use of contracts to strategically source facility needs. Additionally, the healthcare system should be aware of and comply with the requirement for cardholders to submit a ratification request for any identified unauthorized commitments and ensure cardholders are responsive to requests for audit to assess effectiveness of internal controls. Failure to properly manage the purchase card program increases the risk of insufficient documentation, improper purchases, and missed opportunities to optimize cost savings. The healthcare system should continue to ensure reviews are conducted to identify internal control weaknesses to mitigate the risk of fraud, waste, and abuse.

Recommendations 2–4

The OIG made the following recommendations to the VA Philadelphia Healthcare System director:

2. Ensure cardholders comply with VA financial policy record retention requirements.
3. Establish controls to confirm approving officials and purchase cardholders review purchases for VA policy compliance and ensure contracting is used when it is in the best interest of the government.
4. Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.

VA Management Comments

The VA Philadelphia Healthcare System director concurred with recommendations 2–4.

To address recommendation 2, the director said three options may be considered for the safeguarding of purchase card documentation and information. Additionally, the director reported that her office will establish a request process to ensure approving officials are providing sufficient oversight regarding prior approvals, as is currently practiced by other facilities within VISN 4, whereby a cardholder submits a preapproval form. The director said this process will ensure compliance with financial policy requirements by adding a measure of accountability among approving officials and cardholders for proper purchase validation.

For recommendation 3, the director said cardholder and approving official responsibilities, as well as compliance with policy, will be incorporated into applicable employee performance plans. The medical center will publish a memorandum outlining purchase card responsibilities. To enhance VA's purchasing authority by using strategic sourcing, the director said the purchase card program manager will continue to generate the station's quarterly report on the history of purchase card transactions for dissemination to the service line chiefs for review. The service

line chiefs will identify repetitive orders or potential vendors for contracts in accordance with strategic sourcing initiatives.

To address recommendation 4, the director said any cardholder identified as having exceeded the authorized single-purchase limit will be required to submit a ratification package in accordance with standard operating procedure.

OIG Response

The healthcare system director's action plans are responsive to the recommendations. Although the director said actions addressing recommendation 4 have already been completed, the OIG received no evidence or supporting documentation to evaluate them. The OIG will monitor implementation of the planned actions and will close the recommendations when it receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

III. Inventory and Supply Management

Supply chain management is the integration and alignment of people, processes, and systems across the supply chain to manage all product and service planning, sourcing, purchasing, delivering, receiving, and disposal activities. VHA policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to ensure veterans receive high-quality care.⁶² Supplies are received at the warehouse and distributed to a primary inventory point and then, when established by a healthcare system, to a secondary inventory storeroom at a medical facility.⁶³ Secondary inventory storerooms are maintained by the clinical staff who use these supplies.

The Generic Inventory Package is the software system authorized to manage the receipt, distribution, and maintenance of expendable supplies used throughout VA. It uses an item master file, created within IFCAP, to store and track information, such as the description, mandatory source or vendor details, unit price, packaging, and manufacturing information for each item. Per VHA policy, it is essential that this information be entered into the IFCAP system completely and correctly. Access to item master files in IFCAP is controlled to ensure data integrity and accuracy. The VA medical facility chief supply chain officer is responsible for maintaining the access list and reviewing it each calendar year.⁶⁴

The team reviewed the following areas:

- **Stock performance metrics.** The team assessed whether the healthcare system met the performance metric for days of stock on hand. The days-of-stock-on-hand metric promotes inventory stock level efficiency for items purchased through the MSPV program and for non-MSPV items.
- **Supply chain management oversight.** The team assessed data validity, identified factors that affected the healthcare system's supply chain management, reviewed required quarterly physical inventory for "A" classified items, and determined if the healthcare system was properly maintaining and reviewing edit access to the item master file.⁶⁵

⁶² VHA Directive 1761.

⁶³ A primary inventory point contains all expendable items for an inventory account that are replenished by placing orders outside of the VA medical facility. When established, secondaries serve as points of distribution related to, and replenished from, a primary inventory. A primary with no secondary is referred to as a stand-alone primary inventory.

⁶⁴ VHA Directive 1761.

⁶⁵ "A" classified items, which garner the highest 80 percent annual usage by dollar value, are reviewed quarterly. Only clinical item (versus nonclinical) inventories were assessed for this inspection; VHA defines clinical items as nondurable disposable healthcare materials ordered or prescribed, which are primarily and customarily used to serve a medical purpose. Physical inventories of "A" classified items are to be conducted each quarter.

Finding 3: The Healthcare System Should Ensure Supply Chain Operations Comply with VHA Policy and Inventory Data Are Accurate

The OIG found that the healthcare system could improve the efficiency of inventory management by ensuring stock levels and expendable inventory data values are recorded in the Generic Inventory Package. In addition, leadership vacancies and staffing shortages may have affected the ability of the healthcare system to establish local processes and procedures, develop training plans, and increase awareness of internal controls for consistent supply chain oversight. The healthcare system did not complete physical inventory memoranda or annual reviews of the master file edit access list according to policy and did not meet performance metrics that measure days of stock on hand. Failure to properly align systems, personnel, and processes across the supply chain can threaten the healthcare system’s ability to effectively plan, mitigate issues, and budget for the purchase of supplies that meet patient care needs.

Data Validity and Conversion Factors

The team assessed conversion factor data, which can affect the accuracy of days-of-stock-on-hand metrics. The team accessed the Supply Chain Common Operating Picture (SCCOP) dashboard to review the healthcare system’s conversion factor primary inventory report.⁶⁶ A unit conversion factor is computed by dividing the quantity purchased by the quantity issued.⁶⁷ This factor connects how a supply item is purchased and issued—for example, a vendor may sell an item in cases of 24 cans, but the end user (hospital staff) receives individual cans from that case. A “false” conversion factor showing in the SCCOP dashboard may be the result of a conversion being entered into the Generic Inventory Package system incorrectly. Inaccurate inventory data could lead to incorrect item quantities and values recorded in the inventory system and could result in the healthcare system not having needed supplies to provide care to veterans. At the time the report was accessed, 898 of 5,912 conversion factors (15 percent) for clinical primary inventory points, had false results.⁶⁸ The chief logistics officer reported that data integrity issues may have been due to inadequate training.

The assistant chief logistics officer reported a lack of local standard operating procedures for inventory staff; in addition, staff reported a lack of training on inventory supply systems, as well as for conducting other inventory responsibilities. Although there are mandatory classes on VA’s

⁶⁶ The Conversion Factor Primary Inventory Point report was accessed by the inspection team on September 15, 2022, from the SCCOP dashboard; this report details point-in-time conversion factor data at the healthcare system.

⁶⁷ Department of VA Office of Information and Technology Product Development, Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) Version 5.1 Generic Inventory User’s Guide, October 2000, rev. October 2019. A conversion factor expresses the ratio between the vendor’s unit of measure and the unit of issue and is used to translate the order quantities into supply station amounts.

⁶⁸ When a conversion factor does not equal an item’s unit of receipt (i.e., bought by the case) divided by the unit of issue (distributed by the case), it is flagged as a “false” result.

training site, the healthcare system lacked structured training or written policy for more specific inventory tasks, such as the calculation of conversion factors or for dealing with expired or spoiled items.⁶⁹ Healthcare system staff reported using the SCCOP dashboard reports; however, staff interviewed had no knowledge of the conversion factor primary inventory report. Staff did report awareness of the conversion factor calculation but detailed inconsistencies among training and reference materials concerning conversion factor calculation. One staff member reported becoming familiar with conversion factors from knowledge sharing among colleagues, while another staff member reported being provided with conversion factor information, later determined as inaccurate.

VHA Directive 1761 states that the chief supply chain officer is responsible for training supply chain management staff and must set up local policies and procedures that include a routine monitoring of reports to ensure supply chain performance measures are maintained.⁷⁰ The chief and assistant chief reported future development of standard operating procedures for all logistics functions. Standard operating procedures could provide staff with a better understanding of required inventory management reports and written instruction for key processes, including the calculation of conversion factors.

Despite potential conversion factor and other data inaccuracies that can decrease the healthcare system's ability to meet the performance metric for days of stock on hand, the assistant chief of logistics and staff have reported that they use the autogeneration tool required by policy.⁷¹ Automated ordering of stock items is intended to encourage efficient purchasing by reducing separate purchases to the same vendor within short periods of time. As processes and data become more reliable, the facility can begin to recognize even greater efficiencies through the consistent use of the automated ordering of stock.

Leadership Vacancies, Staffing Shortages, and Supply Chain Management Oversight and Controls

During the site visit, the team interviewed supply chain services leaders and staff to assess factors that affected the healthcare system's oversight controls and efficiency. Logistics leaders reported inconsistent leadership, inadequate staffing levels, and a lack of local processes at the facility, all of which may have hindered monitoring efforts necessary for the reduction of data integrity issues and oversight of stock levels. Issues concerning data integrity and oversight of stock levels may have affected the healthcare system's ability to meet the days-of-stock-on-hand performance metrics. The healthcare system has begun implementation of procedures in response

⁶⁹ VA's Talent Management System is a web-based training site (VA Identity and Access Management System (IAM)) where VHA staff access various job-related training courses.

⁷⁰ VHA Directive 1761.

⁷¹ VHA Directive 1761.

to the inventory and supply management issues at the facility. The facility reported that in April 2022 the VISN 4 chief supply chain officer conducted a quality control review. This review yielded over 50 items requiring corrective action plans to address deficiencies, 27 of which had been resolved as of September 2022. Action plans were developed and submitted to the VISN for review and approval for the remaining items requiring long-term solutions.

The former acting chief, current chief, and assistant chief logistics officer all reported challenges with staffing shortages within multiple levels of the logistics service. From March 2021 to September 2022, the logistics service was assigned four different chiefs. Although a chief is now permanently assigned to the role, lack of consistent leadership may have affected continuity in oversight processes and procedures.

The former acting chief logistics officer reported many staffing vacancies during the past year. The assistant chief corroborated these issues and added that logistics had high attrition rates and continuously hires to fill staffing gaps. As of November 2022, the facility reported 11 positions within logistics service that were vacant. Specifically for the expendable logistics service line, the vacancies include six supply technicians, one lead supply technician, and one supervisor supply technician. The staff further reported a lack of equitable distribution of supply items among inventory management specialists.⁷² As of early November 2022, three inventory management specialists managed approximately 57 percent of supply items for clinical primary inventory points—a total of 1,633 out of 2,850 items. The remaining seven inventory management specialists managed approximately 43 percent—a total of 1,217 supply items. The inability to attract, retain, and utilize sufficient personnel has the potential to hinder consistent oversight and management of supply items.

Quarterly Physical Inventories and Facility Item Master File Edit Access List

The team also assessed oversight related to the required quarterly physical inventory of “A” classified items and for the facility inventory master file edit access list. Although physical inventories were conducted for “A” classified items, which correlate with the highest 80 percent of annual usage dollars, only two of the three memoranda documenting the inventory counts were signed by the required personnel.⁷³ VHA policy designates the chief supply chain officer as responsible for signing and sending such memoranda to the VISN chief logistics officer and

⁷² The calculations only considered clinical primary inventory point items.

⁷³ The ABC classification method states that inventory point items with the highest 80 percent of annual usage by dollar value are classified as “A.” Items with the next highest 10 percent of annual usage are classified as “B.” Finally, items representing the remaining 10 percent are classified as “C.” The formula for calculating the classification of an item is the quantity multiplied by the average unit price. Only clinical item (versus nonclinical) inventories were assessed for this inspection.

deputy network director.⁷⁴ However, the chief logistics officer informed the inspection team that the VISN does not ask for copies of the memoranda; instead, they are kept on file and provided when requested. Alternatively, each quarter, the healthcare system enters its accuracy rate onto a spreadsheet created by the VISN—when a corrective action plan is needed, they are uploaded to a SharePoint site for the VISN’s review. The healthcare system’s process was not consistent with policy; VHA policy states that physical inventory memoranda are to be sent by the VA medical facility chief supply chain officer to the VISN chief logistics officer and deputy network director.⁷⁵ By monitoring the memoranda, leaders acknowledge their awareness of any inaccuracies and can work to identify, monitor, and mitigate potential issues that may affect veteran care.

The inspection team also determined if the healthcare system maintained and reviewed a facility inventory master file edit access list. The edit access list documents all individuals at a VA medical facility who have permissions to enter or modify data within the item master file, a file which holds pertinent supply item details.⁷⁶ Although an edit access list was maintained, and a process was in place to review access to the inventory system, the inspection team was not provided documentation to support that the chief supply chain officer reviewed the list. The chief logistics officer informed the inspection team that per direction provided by the Office of Information and Technology, the healthcare system’s automated data processing application coordinator reviews staff access to Veterans Information Systems and Technology Architecture biannually. The chief logistics officer reported that a review was conducted by the application coordinator on August 26, 2022. There was no evidence that the chief logistics officer assessed the inventory master file edit access list to conduct a review, which is required by VHA policy to be conducted each calendar year.⁷⁷ Oversight of the list by proper personnel helps to ensure unauthorized staff do not the access the inventory system and input erroneous data. Accurate data for inventory supplies is necessary for the continuity of healthcare services for veterans.

Days-of-Stock-On-Hand Performance Metrics

The SCCOP dashboard tracks the use of expendable and nonexpendable items. The dashboard, which receives part of its data from the Generic Inventory Package, lists the performance measure for expendable supplies purchased from MSPV as 15 days or fewer of stock on hand,

⁷⁴ VHA Directive 1761. At the VA Philadelphia Healthcare System, the chief supply chain officer roles and responsibilities are assigned to the chief logistics officer.

⁷⁵ VHA Directive 1761.

⁷⁶ The item master file is a file within the IFCAP software program used for the storage of item information to include item description, mandatory source, vendor, unit price and packaging, and product and manufacturer information. This file links with the request and procurement files and provides for the extraction of item procurement history.

⁷⁷ VHA Directive 1761.

whereas non-MSPV items should have 30 days or fewer of stock on hand.⁷⁸ The inspection team accessed the SCCOP dashboard and downloaded the healthcare system’s “MSPV Days of Stock on Hand” and “Non Prime Vendor Days of Stock on Hand” reports for FY 2022, available from October 2021 to June 2022 at the time of the inspection. The team reviewed the healthcare system’s overall performance and clinical primary inventory points within the supply chain management service line to determine if MSPV and non-MSPV items met the days-of-stock-on-hand metric.⁷⁹

The team determined that the healthcare system averaged 30 days of stock on hand for MSPV items and 59 days of stock on hand for non-MSPV items during the review period. In response to the COVID-19 pandemic, the healthcare system received a waiver, from May 7, 2020, through March 31, 2022, to suspend the days-of-stock-on-hand performance measures. This waiver overlapped with part of the inspection team’s review period therefore the team did not take exception for missed metric goals from October 2021 to March 2022.⁸⁰ The inspection team also evaluated a sample of clinical primary inventory points within the supply chain management service line that were subject to days-of-stock-on-hand metrics. The team found 10 of 11 MSPV clinical primary inventory points (91 percent) and 18 of 21 non-MSPV clinical primary inventory points (86 percent) did not meet the days-of-stock-on-hand metric; the inventory points included two top-dollar clinical points for both MSPV and non-MSPV items.

The assistant chief logistics officer reported that the ability to meet the days-of-stock-on-hand levels was still affected by pandemic-related supply chain issues and communication between inventory and medical staff. One staff member noted that supplies were often not available through the healthcare system’s prime vendor following the pandemic, resulting in continued use of alternate vendors, sometimes purchasing in bulk rather than at the lowest quantity through the prime vendor. One staff member also reported that certain items sat dormant until procedures were scheduled, versus more regularly used inventory items, due to the nature of the primary point. A lack of communication with medical staff was also reported as affecting compliance with the days-of-stock-on-hand metric. One staff member reported that service lines frequently requested items for purchase and upon delivery determined those items were no longer needed. Another staff member reported that there were instances when physicians left VA employment,

⁷⁸ The national MSPV program provides a customized distribution system to meet or exceed facility requirements through a just-in-time distribution catalog ordering process.

⁷⁹ The inspection team only considered clinical primary inventory points for analysis, versus ## inventory points, because ## inventories are not held to the days-of-stock-on-hand metric. A ## will be placed in front of the primary name for inventory points that are not part of the two mandatory categories reported in performance measures.

⁸⁰ During the COVID-19 pandemic, facilities were provided a waiver for compliance with the days-of-stock-on-hand metric. The memo expired March 2022 and facilities were expected to resume compliance. The VA Philadelphia Healthcare System only met the metric for MSPV items for one of the three of months during which the waiver expired and did not meet the metric for non-MSPV items for any of the three months assessed.

without informing staff, resulting in the unnecessary purchase of items they had specifically requested from logistics.

The chief and former acting chief logistics officer reported that stock level oversight issues also occurred because some service lines do not use the supply chain request portal to request new supply items. Each VA medical facility must use the portal's request tool to request, review, and approve for use all new clinical products for the VA medical facility. Use of the tool to review and approve all new expendable clinical products, reusable medical equipment, and reusable medical instruments prior to their use for direct patient care encourages standardization, compatibility with current processes and equipment, as well as economical purchasing and distribution. The current chief logistics officer and staff noted that service lines have circumvented the use of this approval process in efforts to obtain requested items in a timelier manner. One staff member reported instances of multiple requests for a one-time buy of the same clinical item. In these instances, the service lines should be using the tool for proper review and approval of items.

Finding 3 Conclusion

Supply chain management oversight at the VA Philadelphia Healthcare System was not sufficient to ensure the proper oversight of expendable supplies. Establishing local processes and procedures for monitoring reports in the SCCOP dashboard, the Generic Inventory Package, or other software systems, as well as developing a plan for staff training, could increase the awareness of inventory management controls and increase the reliability of inventory data. Ensuring that quarterly physical inventory memoranda of "A" classified items are properly completed and made available to the VISN, and that the annual facility item master file edit access list review is conducted in accordance with VHA policy, could improve the healthcare system's management of inventory.⁸¹ Lack of local policies and procedures, as well as unreliable inventory data, can lead to purchasing unnecessary supplies and adversely affect patient care. By addressing the OIG's recommendations, the healthcare system can more effectively plan and budget for supplies to operate and meet patient care needs.

Recommendations 5–8

The OIG made the following recommendations to the VA Philadelphia Healthcare System director:

5. Ensure the chief supply chain officer establishes local processes and procedures so that all necessary reports are routinely monitored on the Supply Chain Common Operating Picture, the Generic Inventory Package, or other inventory sites or software systems to

⁸¹ VHA Directive 1761.

ensure performance measures are maintained, as required in the Veterans Health Administration's Directive 1761, *Supply Chain Management Operations*.

6. Ensure supply chain managers implement a plan for staff training to increase awareness of internal controls and data reliability issues, such as conversion factor, within the Generic Inventory Package.
7. Ensure the chief of supply chain services provides quarterly physical inventory memoranda of "A" classified items to Veterans Integrated Service Network personnel, as required in the Veterans Health Administration's Directive 1761, *Supply Chain Management Operations*.
8. Ensure the chief supply chain officer reviews the facility item master file edit access list of all individuals at the VA medical facility who have permissions to enter or modify data within the item master file each calendar year, as required in the Veterans Health Administration's Directive 1761, *Supply Chain Management Operations*.

VA Management Comments

The VA Philadelphia Healthcare System director concurred with recommendations 5–8.

To address recommendation 5, the director said the logistics expendable supervisor reviews nine key metrics daily in SCCOP, and supply chain leaders review metrics monthly in both expendable and nonexpendable areas. The team responsible for nonexpendables will review key metrics with the VISN nonexpendables team on a quarterly basis, and the team responsible for expendables will be looking to establish a similar process.

For recommendation 6, the director said supply chain leaders developed monthly training plans specific to each business unit and a standard operating procedure. The director said by executing the respective plans, staff should become more aware of internal controls and the importance of data reliability.

To address recommendation 7, the director said a signed memorandum will be forwarded to the VISN chief logistics officer and deputy network director.

For recommendation 8, the director said the chief supply chain officer will review the facility item master file edit access list and edit permissions as needed at the beginning of each calendar year.

OIG Response

The healthcare system director's action plans are responsive to the recommendations. Although the director said actions addressing some of the recommendations have already been completed, the OIG received no evidence or supporting documentation to evaluate them. The OIG will monitor implementation of the planned actions and will close the recommendations when it

receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

IV. Pharmacy Operations

The VA Philadelphia Healthcare System spent almost \$87.9 million on prescription drugs in FY 2021. This represented just over 11 percent of the healthcare system's total budget of about \$767.6 million for the year.⁸² Because pharmacy costs account for a substantial percentage of any medical center's budget, medical center leaders need to analyze spending and identify opportunities to use pharmacy dollars more efficiently. The inspection team used the pharmacy cost model in the OPES efficiency grid as a baseline for pharmacy operational efficiency at the healthcare system.

The team reviewed the following pharmacy areas:

- **OPES pharmacy expenditure data** are designed to allow VHA facilities to track costs and identify potential opportunities for improvement.
- **Inventory turnover rate**, or the number of times inventory is replaced during the year, is the primary measure to monitor the effectiveness of inventory management per VHA policy.⁸³ Low inventory turnover rates can indicate inefficient use of financial resources.
- **End-of-year purchases of pharmacy drugs** can lower the inventory turnover rate and increase the total replenishment cost of pharmacy inventories. These purchases complicate pharmaceutical inventory management and are to be avoided, according to VHA policy and Pharmacy Benefits Management program office guidance.⁸⁴
- **The B09 reconciliation** process can help VA medical center pharmacies assure they are making correct payments for the drugs they receive. Without this reconciliation process, there is no assurance that the amount paid to the prime vendor agrees with the amount of goods received. These reports are prepared monthly to reconcile pharmaceuticals purchased and ordered with pharmaceuticals that are invoiced and received at the facility. A memorandum and supporting documentation are provided to the finance service for review and concurrence. The results of the reviewed reconciliation are to be returned and retained with the pharmacy service, and any identified discrepancies are to be corrected in a timely manner.

⁸² "Office of Productivity, Efficiency & Staffing (OPES) Pharmacy Expenditure Model (based on FY 2021 data)" (website), OPES, accessed August 16, 2022, <http://opes.vssc.med.va.gov/Pages/Pharmacy-Model.aspx> (this website is not publicly accessible).

⁸³ VHA Directive 1761, app. H. Inventory turnover is based on total dollar value purchased for the previous 12 months divided by the dollar value of items on the shelf.

⁸⁴ VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022.

Finding 4: The Healthcare System Could Improve Pharmacy Efficiency and Strengthen Oversight Controls

The OIG found the healthcare system could improve pharmacy efficiency by narrowing the gap between expected and observed pharmaceutical costs, achieve an inventory turnover rate closer to the VHA-recommended level, and avoid end-of-year-purchases. In addition, the healthcare system did not complete some B09 monthly reconciliations.⁸⁵ Failure to properly manage pharmacy operations can lead to increased replenishment costs, overstocking, spoilage, and diversion of drugs, as well as decrease the funding available to meet other healthcare system and patient care needs.

OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model, which identifies variations in pharmacy costs among VHA facilities, showed the healthcare system spent about \$17.6 million more than the expected cost of about \$70.3 million in FY 2021. Based on these numbers, the facility's observed-minus-expected ratio was about 1.25, which ranked it 137 out of 139 VHA facilities for pharmacy drug cost efficiency.⁸⁶

For FY 2019 through FY 2021, the healthcare system averaged approximately \$8.4 million in annual potential for missed cost savings, which reflects the fact that the system spent more than expected for similar facilities as outlined within the model. In FY 2019 alone, the healthcare system reported almost \$3.4 million opportunity for savings. The opportunity increased to about \$4.3 million in FY 2020 and then increased significantly in FY 2021 to about \$17.6 million. Figure 3 describes the healthcare system's year-over-year increases in observed-minus-expected costs.

⁸⁵ VHA Directive 1108.07(1), *Pharmacy General Requirements*, March 10, 2017, amended January 26, 2021. The chief of pharmacy services is responsible for reviewing the Pharmacy Prime Vendor (PPV) Line Item Report (B09 report) and reconciling the report with VA Form 1358 to ensure that the pharmacy is making correct payments for what is received and there is documented evidence (signature and date of review) that it has been completed.

⁸⁶ The OPES pharmacy expenditure model uses the terms "observed minus expected" and "potential opportunity" to describe the gap between a facility's actual drug costs and expected drug costs. This difference represents the amount associated with potential efficiency improvements. An observed-minus-expected ratio above 1.0 indicates that a facility may have opportunities to reduce its pharmacy costs.

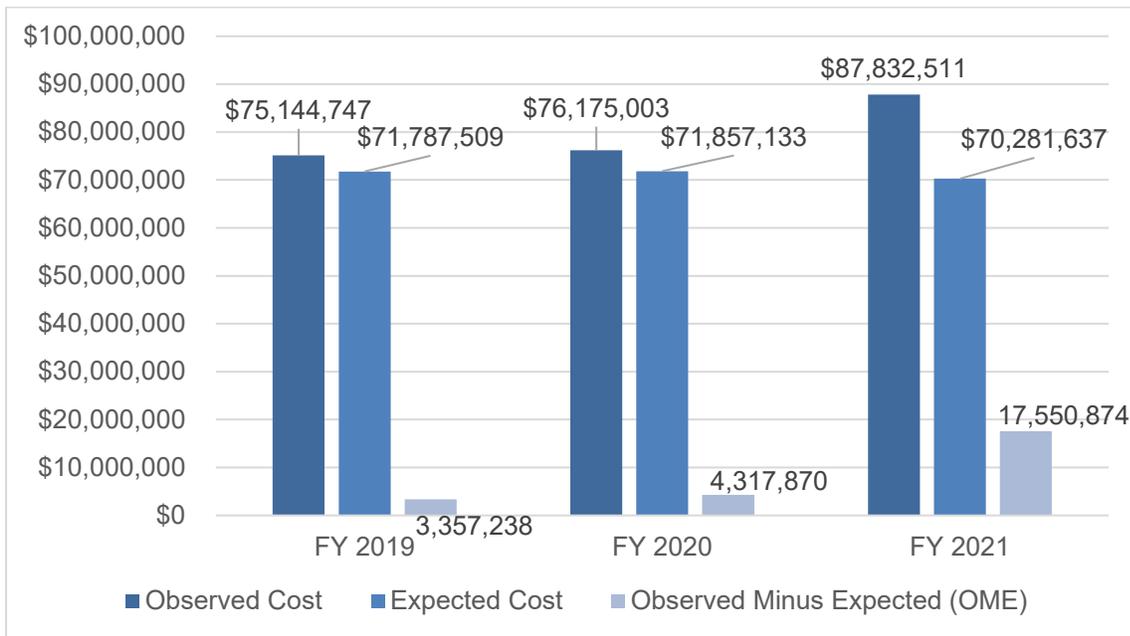


Figure 3. Observed versus expected drug cost, FY 2019–FY 2021.

Source: OPES pharmacy expenditure model.

Note: The OPES data models are based on the previous fiscal year data (i.e., the FY 2021 data model was based on FY 2020 data).

Pharmacy personnel stated that they were not familiar with the OPES data. In addition, pharmacy personnel also reported that due to staff shortages and high turnover, the pharmacy staff lacked the facility-specific knowledge and experience to accurately explain the OPES variance of \$17.5 million between observed and expected costs. Pharmacy procurement staff must balance the utilization pattern of the VA medical facility with the knowledge of certain aspects of medical care to determine the appropriate drug quantities to order. Large purchases or irregular replenishments that override established normal stock levels and reorder points can increase the risk of damage, outdating, contamination, and obsolescence of inventory items. Overstocking can also signal an inefficient use of financial resources by purchasing and storing more inventory than is required.

The inspection team looked for abnormal order quantities during the review period and identified that the purchase of intravenous solution with electrolytes increased by about \$14.5 million, from about \$2.7 million in FY 2020 to approximately \$17.2 million during FY 2021, an increase of about 545 percent. According to the VISN managerial cost accounting manager, this issue occurred due to a mismatch in a pharmacy data file, whereby the unit of measure used to record the volume of medication dispensed was different than the unit of measure associated with pricing. The VISN’s managerial cost accounting veterans equitable resource allocation manager reported that internal reporting processes are in place to identify and correct these errors in a timely manner. The Managerial Cost Accounting Office provides reports to the facility each month that identify outliers in unit cost, unit dispensed, or any reconciliation errors contrary to

what is in the national drug file. Facilities are instructed to review the reports and make necessary corrections in a timely manner. The facility reports show that this error was due to a costing error and new tools are now in place to correct issues like these from occurring in the future. From March 2022 through June 2022, there was an acting chief of pharmacy and a staff shortage. The chief's appointment became permanent in July 2022; however, the lack of consistent leadership may have affected effectiveness of such error alerts as well as continuity of oversight processes and procedures within the pharmacy service.

In addition, the healthcare system uses the national Pharmacy Benefits Management office-provided lost opportunity cost report to evaluate initiatives for cost-saving opportunities. The review team assessed the lost opportunity cost report for the healthcare system for FY 2022 and noted it did not achieve about \$1.8 million annual savings goal identified by the Pharmacy Benefits Management office for FY 2022, reaching nearly \$1.2 million in savings, or about 65 percent of the goal. The chief of pharmacy said this was also due to a lack of continuity in the leadership position and a staffing shortage. The healthcare system is working toward staffing the team to support the newly assigned pharmacoeconomist. However, officials reported that efforts are being made to fully understand the required processes and procedures.

Pharmacy Inventory Management

VHA adopted ABC classification principles to increase accountability for inventory management and to establish more rigorous requirements for higher-dollar usage inventory items. This method is based on annual inventory usage, in dollars, of all items at a specific inventory point. To establish ABC categories, items are ranked from higher-dollar amount of usage to lowest. Items with the highest 80 percent of annual usage are classified as "A," items with the next highest 10 percent are classified as "B," and the remaining 10 percent are classified as "C."⁸⁷

Based on VHA policy, which states that inventory turnover is the primary measure of the effectiveness of inventory management, the VA Pharmacy Benefits Management office recommended an annual inventory turnover goal of 12–16 times for items classified as "A" and six to 10 times for "B" and "C" items.⁸⁸ Higher inventory turnover rates are associated with decreased inventory carrying cost, the cost associated with holding inventory storage. On the other hand, low inventory turnover could indicate inefficient use of financial resources and the inability to properly forecast the needed amount of pharmacy drugs to meet patient care needs.

In August 2022, the turnover rate for pharmacy inventory was inconsistent with meeting the national inventory turnover target rates and reflected an inventory turnover rate of 12.26 times for "A" items, 6.2 times for "B" items and 4.45 times for "C" items.

⁸⁷ VHA policy mandates the ABC inventory analysis method. VHA Directive 1761, app. E.

⁸⁸ VHA Pharmacy Benefits Management office, email message to the VA OIG Office of Financial Inspection, January 2021; VHA Directive 1761, app. E.

VHA policy also describes requirements that apply specifically to the pharmacy service at all VA medical facilities. One such requirement is that pharmacy services use the pharmaceutical prime vendor's inventory management software for the electronic management of facility inventories.⁸⁹ According to the pharmacy staff, inpatient pharmacy drug inventories were not maintained in the prime vendor's software or any other inventory management software. These inventories were managed by "walking the shelves" rather than more accurate inventory management practices, such as calculated reorder points and reorder quantities, as required by VHA policy.⁹⁰

The team also found pharmacy staff were not implementing inventory management practices requiring the placement of bar codes on all items that will be distributed and were not consistently using handheld barcode readers.⁹¹ Pharmacy officials stated that they were unable to use handheld scanners due to issues with wireless connectivity. Specifically, the structure of the building prevents Wi-Fi or hot spot connectivity for the readers to function properly.⁹²

Additional challenges were reported by a procurement technician within outpatient pharmacy regarding the use of the ScriptPro information management system. The healthcare system implemented the system about two years ago in the outpatient pharmacy.⁹³ Due to a lack of training, pharmacy staff did not know how to use the system. Pharmacy staff reported that they have had to instead manually count the pharmaceuticals to determine quantities showing in the system and items on shelves.

End-of-Year Purchases of Pharmacy Drugs

The OIG found that the healthcare system had a sharp increase in pharmaceutical drug expenditures during the last month of each fiscal year analyzed. The healthcare system averaged about \$6.7 million in monthly expenditures during the 11 months of FY 2021, which jumped to about \$14 million in the last month. In FY 2020 the healthcare system averaged about \$6 million in monthly pharmaceutical drug expenditures during the 11 months and reported about \$8.4 million in expenditures for the last month. Figure 4 shows the spike in pharmacy drug expenditures during the last months of FY 2020 and FY 2021.

⁸⁹ VHA Directive 1761, app. H.

⁹⁰ VHA Directive 1761, app. B.

⁹¹ VHA Directive 1761, app. D.

⁹² A "hot spot" is an area where wireless Internet connection is available. *Merriam-Webster*, "hot spot," accessed February 28, 2023, <https://www.merriam-webster.com/dictionary/hot%20spot>.

⁹³ VA Enterprise Architecture Repository, "ScriptPro – workflow system that provides real-time inventory tracking, order generation, electronic transmission, and inventory receiving for outpatient pharmacies," accessed February 28, 2023, <https://vaww.vear.ea.oit.va.gov/#main.htm>.

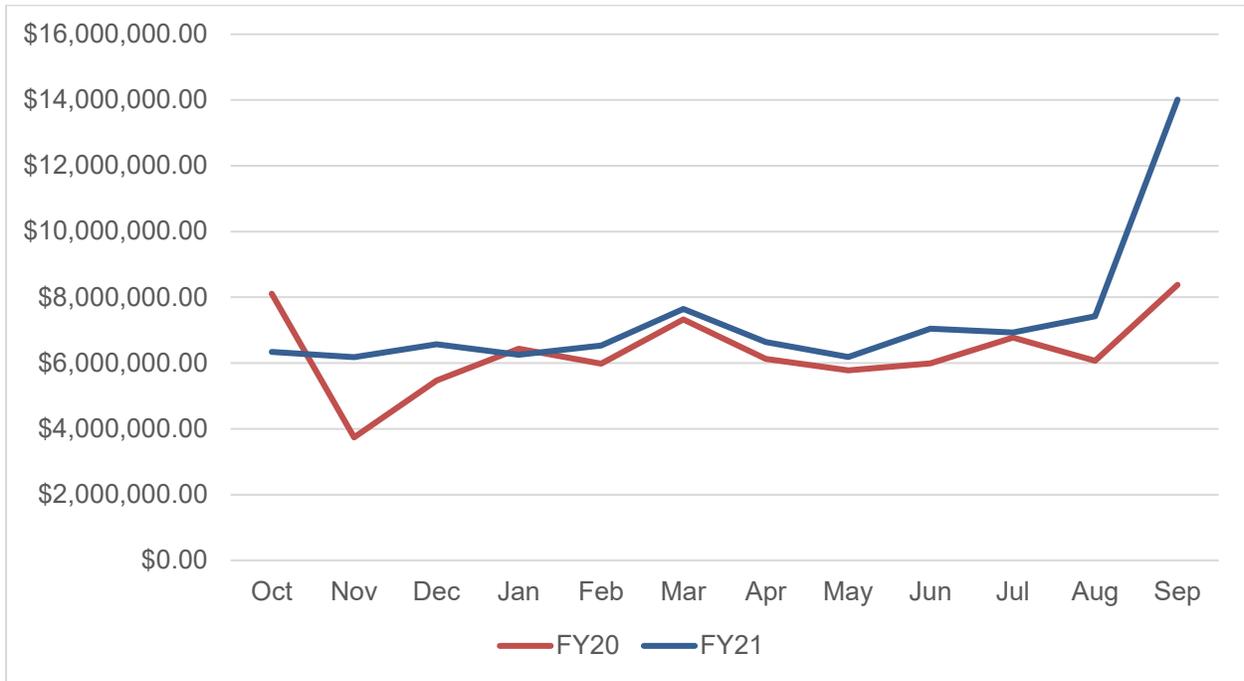


Figure 4. VA Philadelphia Healthcare System’s monthly drug expenditure data for FY 2020 through FY 2021 (October 2019–September 2021).

Source: *OIG analysis of VA FMS (FMS 830/887 report).*

VHA policy and guidance from the Pharmacy Benefits Management office state that “end-of-year purchases make pharmaceutical inventories increasingly difficult to manage and need to be avoided.”⁹⁴ Pharmacy personnel reported that the healthcare system’s fiscal office initiated the request for the end-of-year spending and gave the pharmacy service only a few days’ notice to spend the remainder of the annually appropriated funds. Interviews further confirmed that the identified end-of-year purchases include orders for high-cost drugs or pharmaceuticals that have a longer shelf life. Despite purchasing efforts to mitigate the risk for overstocking and premature spoilage, the facility was not in compliance with guidance. End-of-year purchases are discouraged, and stock levels should be kept at a minimum for efficient use of financial resources.

B09 Reconciliation Process

VHA policy requires a review of the B09 report and reconciliation of that report with VA Form 1358 and other supporting documentation.⁹⁵ VA offices may use VA Form 1358 as an obligation control document only for certain limited uses to record the initial obligation and any subsequent

⁹⁴ VHA Directive 1761.

⁹⁵ As previously noted, the B09 reconciliation process is how VA medical center pharmacies review what is ordered against what is received to ensure they are making correct payments for the drugs they receive. VHA Directive 1108.07(1).

change in the obligation.⁹⁶ This process is necessary to ensure that the pharmacy is making correct payments for what is received and there is evidence, such as a signature and date of review, that documents the order's completion. The report is generated weekly and is a summary of multiple invoices. VHA policy requires reconciliation of billing statements, verification of items ordered being received, and certification as to accuracy, including maintaining supporting documentation such as receipts, invoices, and packing slips. The pharmacy service must provide a monthly report, with adequate documentation, to the fiscal service stating the VA Forms 1358 and B09 reports were reconciled and note any unresolved discrepancies. VHA policy also states that the pharmacy staff must maintain separation of duties during the Form 1358 ordering process, which requires different staff members to establish, approve, obligate, and receive the goods ordered.⁹⁷

The healthcare system's B09 reconciliation process was not fully compliant with VHA policy. Officials did not submit B09 monthly memoranda and corresponding supporting documentation packages to the fiscal office. Following staffing vacancies, newly assigned officials said they were not aware of this noncompliance with VA policy. The facility reported that the team will familiarize and disseminate the necessary policy requirements to ensure reconciliations are conducted going forward. B09 reconciliations are necessary because payments are made to the prime vendor before the facility receives the pharmaceuticals. Without this documentation, the fiscal service could not complete the full reconciliation as required. If reconciliations are not completed, there is no assurance that the amount paid to the prime vendor is consistent with the goods received.

Finding 4 Conclusion

The healthcare system can improve pharmacy efficiency by narrowing the gap between observed and expected drug costs and by increasing its inventory turnover rate to meet the VHA-recommended level for "C" items and end-of-year purchases. The facility met the national inventory turnover target rate for "A" and "B" items. The healthcare system could further improve efficiency by submitting monthly B09 reconciliation reports to the fiscal office and correcting any discrepancies appropriately.

⁹⁶ VA Financial Policy, "1358 Obligations," in vol. 2, *Appropriations, Funds and Related Information*, chap. 6, app. A, September 2021.

⁹⁷ VHA Directive 1108.07(1).

Recommendations 9–12

The OIG made the following recommendations to the VA Philadelphia Healthcare System director:

9. Develop formalized processes for monitoring and achieving identified efficiency targets and use available pharmacy data to make business decisions.
10. Establish measures to improve compliance with the VA directive to avoid end-of-year pharmaceutical purchases.
11. Develop a plan to align inventory management practices, such as the use of handheld scanners, bar code labeling, and ABC inventory analysis methodology with VHA policy.
12. Establish processes to ensure compliance with the Veterans Health Administration directive to complete the B09 reconciliation process.

VA Management Comments

The VA Philadelphia Healthcare System director concurred with recommendations 9–12.

To address recommendation 9, the director said the pharmacy service will develop a process to review efficiency targets to support and inform decision making in developing goals and monitoring performance. In addition, the facility intends to work with vendor partners in forecasting and decision making and plans to compare cost effectiveness with other VA medical centers within the VISN.

For recommendation 10, the director said the pharmacy service will monitor market trends, respond to discrepancies earlier, identify the top 10 percent highest cost medications, and secure funding for earlier product purchases when market pricing conditions are appropriate to ensure the facility can meet and sustain appropriate par levels throughout the year.

To address recommendation 11, the director said the pharmacy service will work with information technology staff, finance staff, and the primary vendor to assist with bar coding and inventory analysis. Additionally, the healthcare system plans to use handheld scanners, bar code labeling, and inventory analysis methodology consistent with VHA policy.

For recommendation 12, the director said the pharmacy service will submit monthly B09 reconciliation reports to the fiscal office to correct any discrepancies appropriately. This process will be monitored and discussed monthly at pharmacy leadership meetings.

OIG Response

The healthcare system director's action plans are responsive to the recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when it

receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

Appendix A: Healthcare System Profile

Table A.1 provides general background information for the VA Philadelphia Healthcare System, a level 1b high-complexity facility reporting to Veterans Integrated Service Network (VISN) 4.⁹⁸

Table A.1. Facility Data for VA Philadelphia Healthcare System from FY 2020 through FY 2022

Item	FY 2020	FY 2021	FY 2022
Total medical care budget	\$655,618,886	\$752,297,255	\$767,633,638
Number of patients	57,310	63,625	65,927
Outpatient visits	611,418	706,337	678,013
Total medical care FTEs*	2,478	2,625	2,716
Number of operating beds:			
Hospital	141	141	141
Community living center	240	240	240
Domiciliary	40	40	40
Average daily census:			
Hospital	70	107	81
Community living center	85	238	96
Domiciliary	17	72	15

Source: VHA Support Service Center, Trip Pack and Operational Statistics report.

Note: The OIG did not assess VA's data for accuracy or completeness.

* This category includes both direct medical care FTEs in budget object code 1000–1099 (Personal Services) and all cost centers.

According to Veterans Health Administration (VHA) Support Service Center data, the healthcare system's medical care budget increased by over \$96 million, about 15 percent, between fiscal year (FY) 2020 and FY 2021, and increased by over \$15 million, approximately 2 percent, between FY 2021 and FY 2022. The chief financial officer compared VHA Support Service Center expenditures but provided additional insights related to how the facility instead tracks funding by allowance. Despite the differences, both reports presented significant spending at the facility in the care in the community and medical services funding areas for the report period.

The number of unique patients increased by about 2,300 from FY 2021 to FY 2022, which is about a 3.6 percent increase. The program application specialist within health administration detailed the current process for monitoring patient count numbers. Patient counts are sourced from monthly ambulatory care reports run within the Veterans Health Information System

⁹⁸ The facility model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex.

Technology Architecture Imaging system for each location within the healthcare system. Workload reports are compiled monthly, and the spreadsheet reports are uploaded for further review. The information when uploaded is not restricted and therefore available for facilities to easily access when requiring this information for business decisions.

Appendix B: Scope and Methodology

Scope

The team conducted its inspection of the VA Philadelphia Healthcare System from October 2022 to April 17, 2023, including a site visit during the week of October 3, 2022. The inspection is limited in scope and is not intended to be a comprehensive inspection of all financial operations at the VA Philadelphia Healthcare System.

Methodology

The inspection team evaluated financial efficiency practices for FY 2022, as well as first quarter of FY 2023 if available, related to open obligations, days of stock on hand for expendable supplies, and purchase card transactions. The team also analyzed financial efficiency practices related to the facility's pharmacy costs using the FY 2022 OPES data model; however, the FY 2022 data model was based on FY 2021 data.

To conduct the inspection, the team

- interviewed facility leaders and staff,
- identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to managing open obligations, overseeing purchase card transactions, calculating days-of-stock-on-hand metrics, and addressing inefficiencies in pharmacy costs, and
- judgmentally sampled
 - 20 inactive obligations to assess whether the healthcare system identified and reviewed the obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy,
 - 10 obligations with different order amounts from VA's Financial Management System (FMS) to Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) Reconciliation reports to determine if order amounts were accurate and reconciled between VA's FMS and IFCAP, and
- statistically sampled
 - 40 purchase card transactions to determine if there was proper oversight and governance of the purchase card program, as well as to assess the risk for illegal, improper, or erroneous purchases.

Internal Controls

The inspection team assessed the internal controls of the VA Philadelphia Healthcare System significant to the inspection objective. This included an assessment of the five internal control components to include control environment, risk assessment, control activities, information and communication, and monitoring.⁹⁹ In addition, the team reviewed the principles of internal controls as associated with this objective. The team identified internal control weaknesses during this inspection in all four subobjectives assessed—Open Obligations, Purchase Cards, Inventory and Supply Management, and Pharmacy—and proposed recommendations to address the control deficiencies.

Fraud Assessment

The inspection team exercised due diligence in staying alert for the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the inspection objectives, could occur during this inspection. The team did not identify any instances of fraud or potential fraud during this inspection.

Data Reliability

The inspection team used computer-processed data obtained from US Bank files through a corporate data warehouse, a central repository of US Bank data that is updated monthly, and the OPES efficiency opportunity grid. To test for reliability, the team determined whether any data were missing from key fields, including any calculation errors, or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared purchase identification numbers, purchase dates, cardholder names, payment amounts, and vendor/merchant names as provided in the data received for the samples reviewed. Testing of the data disclosed that they were sufficiently reliable for the inspection objectives.

In addition, the team used computer-processed data included in reports from FMS to determine open obligation amounts. The team found that summary-level data were sufficiently reliable for reporting on the healthcare system's open obligations.

Government Standards

The OIG conducted this inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

⁹⁹ GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

Appendix C: Sampling Methodology

Open Obligations

The team evaluated a judgmental sample of open obligation transactions from February through July 2022 to determine whether (1) the VA Philadelphia Healthcare System performed monthly reviews and reconciliations of the reviewed obligations with no activity for more than 90 days to ensure the obligations were valid and should remain open and whether (2) the healthcare system reconciled order amounts between FMS and IFCAP for sampled obligations.

Population

During July 2022, the healthcare system had 846 open obligations, totaling approximately \$97.1 million. Of those open obligations, 203 obligations, totaling approximately \$14.6 million, had no activity for more than 90 days. From February 2022 through July 2022, there were 52 obligations with order amount discrepancies between FMS and IFCAP for three or more months.

Sampling Design

The inspection team selected two judgmental samples:

Inactive obligations. The team selected 20 obligations with no activity for more than 90 days from the July 2022 FMS F850 report. This report lists each open obligation and its remaining balance. Ten obligations were still within the performance period, and the remaining 10 were more than 90 days past the performance period end date.

FMS to IFCAP reconciliations. The team selected 10 obligations with different order amounts between FMS and IFCAP from VA's FMS to IFCAP Reconciliation reports for February through July 2022.

The samples included 30 total open obligations: 20 with no activity for more than 90 days, totaling approximately \$6.9 million; and 10 obligations with different order amounts between FMS and IFCAP, totaling approximately \$1.4 million.

The team requested supporting documentation for each of the 30 sampled transactions, including monthly reviews and reconciliations, financial system screen prints and reports, and emails related to the obligations.

Projections and Margins of Error

The inspection team did not use projections and margins of error because statistical sampling was not used.

Purchase Cards

The inspection team evaluated a statistical sample of FY 2022 purchase card transactions to determine if (1) the VA Philadelphia Healthcare System reviewed purchase card payments to ensure they were adequately monitored, approved, and supported by documentation and (2) the reviewed transactions complied with processes to prevent split purchases and transactions exceeding the cardholder's authorized single-purchase limit and to ensure goods or services were procured using strategic sourcing procedures.

Population

During FY 2022 (October 1, 2021, to September 30, 2022), purchase cardholders at the facility made about 54,600 purchase card transactions totaling approximately \$46.6 million. A statistical sample was selected from transactions from October 1, 2021, to July 31, 2022, totaling about 44,400 transactions for approximately \$38.1 million.¹⁰⁰ This sampling frame was developed inclusive of two strata: potential split transactions and nonpotential split transactions with amounts greater than or equal to \$0. Approximately 1,100 transactions were potential split transactions while nonpotential split purchase transactions comprised of approximately 43,300 transactions.

Sampling Design

For both strata, samples were selected using probability proportional to size within bundle (for potential split purchases) or individual transaction (for other nonpotential split purchases):

Potential split purchases. The team identified potential split purchases as transactions with the same purchase date, purchase card number, and merchant and an aggregate sum greater than the cardholder's authorized single procurement limit.

Nonpotential split purchases. Transactions in this stratum were the remaining transactions with amounts greater than or equal to \$0 after potential split purchase transactions were identified.

The statistical sample included 40 total individual transactions: 23 potential split purchase transactions, totaling approximately \$105,500, and 17 nonpotential split purchase transactions, totaling approximately \$123,000.

To review the sampled transactions, the team requested supporting documentation for each of the 40 sampled transactions, VA Form 0242, and documentation to support the completion of purchase card reviews.

¹⁰⁰ The inspection team pulled a statistical sample with purchase dates between October 1, 2021, and July 31, 2022. During this time, purchase card data was not available for August 1 through September 30, 2022.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this inspection with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate estimates, margins of error, and confidence intervals that account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review.

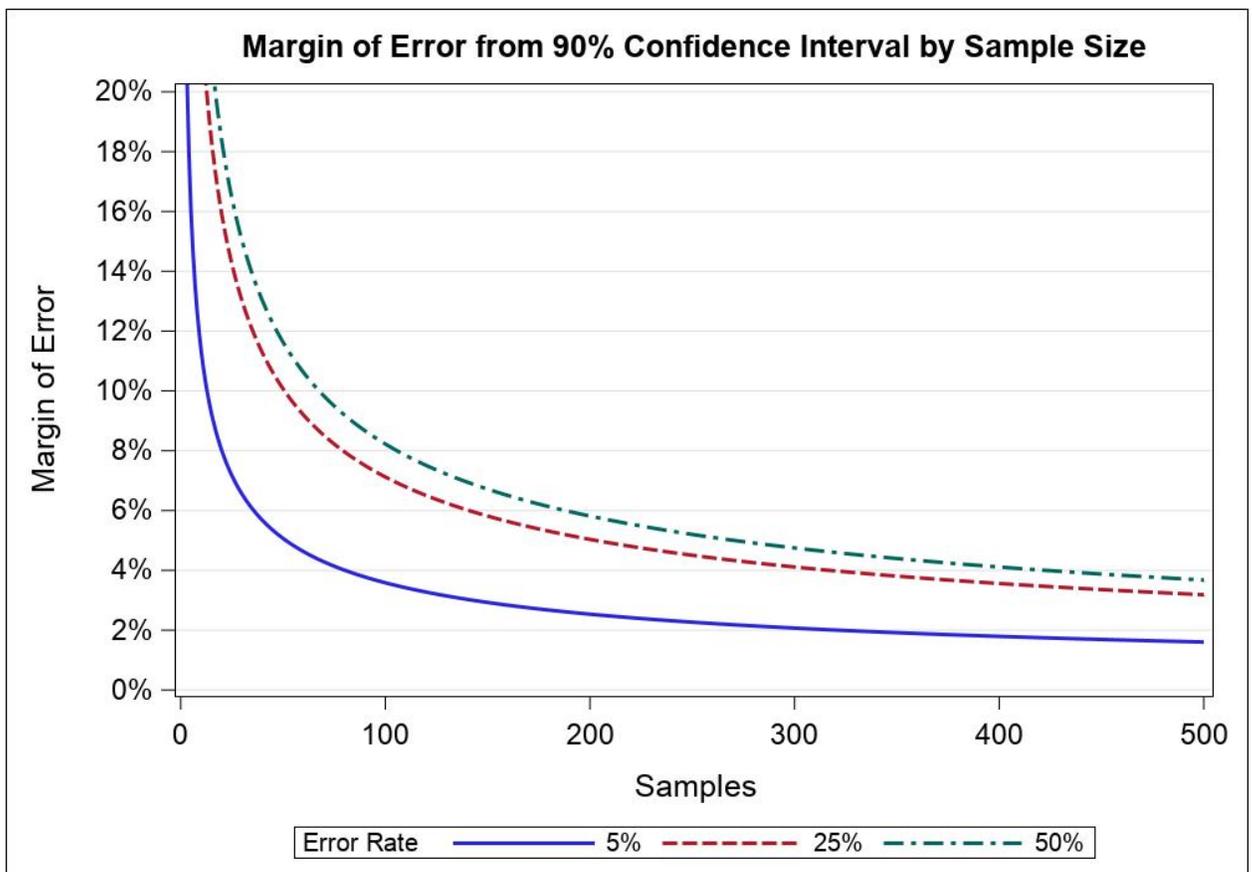


Figure C.1 Effect of sample size on margin of error.

Source: OIG statistician's analysis.

Projections

Based on the results from the sample, the team estimated that approximately 18,500 transactions, totaling approximately \$16 million, were not processed in accordance with VA policy. Further analysis of the sampled transactions indicated that the VA Philadelphia Healthcare System

- may not have supporting documentation for just over 18,200 transactions, totaling about \$15,600,000 and
- may have made split purchases and unauthorized commitments for at least \$106,000.

Tables C.1 and C.2 below show statistical projections of purchase card transaction errors and their dollar amounts.

Table C.1. Statistical Projections for Purchase Card Transaction Errors

Estimate name	Estimate number	90 percent confidence interval			Number of errors	Sample size
		Margin of error	Lower limit	Upper limit		
Overall errors (Percent)	18,463 (42)	8,989 (20)	9,474 (21)	27,452 (62)	20	40
Supporting documentation	18,223	8,989	9,234	27,211	15	40

Source: VA OIG statistician's analysis and team's review of purchase card transactions.

Note: When reporting on total errors combined, a projected "overall errors" estimate is used to avoid double counting transactions.

Table C.2. Statistical Projections for Purchase Card Transaction Error Dollar Amounts

Estimate name	Estimate number	90 percent confidence interval			Number of errors	Sample size
		Margin of error	Lower limit	Upper limit		
Overall errors	\$15,992,056	\$7,462,791	\$8,529,265	\$23,454,847	20	40
Supporting documentation errors	\$15,565,262	\$7,462,528	\$8,102,734	\$23,027,790	15	40
Potential split purchase errors	\$105,529	N/A	N/A	N/A	5	23

Source: VA OIG statistician’s analysis and team’s review of purchase card transactions.

Note: For estimates with poor precision, the one-tailed lower limit for the 90 percent confidence interval is reported. This is a more conservative value than the estimate. These projections have “NA” for the margin of error, lower and the upper limit. When reporting on total errors combined, a projected “overall errors” estimate is used to avoid double counting transaction amounts.

Appendix D: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs ¹⁰¹
1	Ensure healthcare system finance office staff are made aware of policy requirements and reviews are conducted on all inactive open obligations as required by VA financial policy.	\$44,457	
2	Ensure cardholders comply with VA financial policy record retention requirements		\$16,000,000
3	Establish controls to confirm approving officials and purchase cardholders review purchases for VA policy compliance and ensure contracting is used when it is in the best interest of the government.		
	Total	\$44,457	\$16,000,000

¹⁰¹ The OIG questions costs when VA action or inaction (such as spending or failure to fully compensate eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; are not supported by adequate documentation; or are expended for purposes that are unnecessary or unreasonable under governing authorities. Within questioned costs, the OIG must, as required by section 405 of the IG Act, report unsupported costs. Unsupported costs are those determined by the OIG to lack adequate documentation at the time of the audit. Of the estimated \$16,000,000 in questioned costs, approximately \$15,600,000 were unsupported costs.

Appendix E: VA Management Comments

Department of Veterans Affairs Memorandum

Date: May 30, 2023

From: Karen Flaherty-Oxler, Director, Corporal Michael J Crescenz VA Medical Center (642)

Subj: Draft Report Financial Efficiency Review of Corporal Michael J Crescenz VA Medical Center (2022-03503-AE-0147)

To: Assistant Inspector General for Audits and Evaluations (52)

Finding 1: Funds from inactive obligations were not promptly deobligated

Recommendation 1: Ensure that healthcare system finance office staff are made aware of all VA financial policy requirements in the review and management of inactive open obligations, and deobligate any identified excess funds.

Concur or Non-concur: Concur

Target date for completion: May 5, 2023

Director Comments:

Based on the review it was determined that there was a sharp decline in the # of Inactive Obligation due to our accounting staff who have put every effort forward in getting open UDO resolved by sending out emails to appropriate POCs, Chiefs, Contracting Personnel, and upper management

- Renovation of Obligation Tool was complete (April 23) -VISN 04 OBL Database which was implemented as a standard framework for tracking open financial obligations as well as resolution of undelivered orders where follow up comments are provided.
- Training on this Tool was provided to Finance staff and Service chiefs.
- Use of this Obligation database is Mandatory for compliance to VHA Financial Obligations Policy Chapter 5 Appendix F: VHA Review and Reconciliation of Open Obligations.
- This tracking tool will also assist with expired end dates as well as any discrepancies
- Finance dept has hired Internal auditor who will be working on IFCAP/FMS Reconciliation report which will aid in any discrepancies that may arise and get resolved in timely manner.

Mutually working on the IFCAP/FMS Reconciliation Report and utilizing the OBL database in tandem would better serve our need to keep financial records in good order. Fiscal will continually follow up with the individual services and/or Contracting on all open obligations. With the assistance of additional staff, specifically the Internal Auditor, the ATR comments on the OBL database will be populated in a timely and accurate manner.

Finding 2: The Healthcare System Did Not Always Maintain Supporting Documentation or Consider Using Contracts

Recommendation 2: Ensure cardholders comply with VA financial policy record retention requirements.

Concur or Non-concur: Concur

Target date for completion: December 31, 2023

Director Comments: Financial Policy for Government Purchase Card for Micro-Purchases, Volume XVI – Chapter 1B, 010508 Record Retention for Purchase Documentation states *Charge card documents and receipts are required to be maintained for a minimum of 6 years and Cardholders should upload and store all original, unaltered supporting documents electronically to the appropriate document imaging system*

(e.g. iFAMS, CCP, etc.). In the event a cardholder is on leave for an extended period or has separated from service for any reason purchase card documentation is required to be maintained and readily available upon request for audits. Access to these files for this purpose to include routine reviews by the Approving Official (AO) during the certification process are required for the primary and Alternate AO as well. The following options will be considered that best suits the facility's needs and for the safeguarding of purchase card documentation and information.

- Option A (secure): Supporting documentation stored on the cardholder's OneDrive in a designated folder with shared access limited or restricted to cardholder's primary and alternate AO. This is the most restrictive option as access to folders in OneDrive are managed by the individual cardholder.
- Option B (secure): Create a SharePoint site locally for Philadelphia cardholders to upload and store purchase card supporting documentation. Philadelphia SharePoint site administrator can create individual folders by service line and restrict access to the cardholder and their primary/alternate AO assigned them as verified by current VA Form 0242 Governmentwide Purchase Card Certification form.
- Option C (somewhat secure): The Charge Card Portal (CCP) established by the Charge Card Services Division (CCSD) of the Financial Services Center (FSC) is an available electronic storage system for government purchase cardholders to upload and store purchase card supporting documentation. There is a low security risk associated with the portal as read only access to uploaded files is automatically granted to Level 1 Agency/Organization Program Coordinators (A/OPCs) at the Financial Services Center (FSC) in Austin who oversee the portal.

To ensure Approving Officials provide sufficient oversight over the cardholder transaction process with regards to prior approvals CMCVAMC's Director's Office shall establish a LEAF request process as is currently practiced by other facilities within VISN 4 whereby a pre-approval form is submitted by a cardholder. This LEAF pre-approval request then initiates a workflow that proceeds to the Approving Official for initial approval and then to the Service Chief for final concurrence. This process will ensure compliance with Financial Policy requirements by adding a measure of accountability ensuring approving officials and cardholders are properly validating purchases prior to being made. Access to this LEAF process shall be granted to the station Purchase Card Coordinator so as to facilitate quarterly audits and routine reviews for compliance. Additionally, to mitigate future risk of split-purchases made by cardholders, whether intentionally or unintentionally, this pre-approval memo in LEAF is to include a statement from Financial Policy referring to split purchases and what action cardholders are to take when a known requirement at the time of purchase exceeds the cardholder's single procurement limit and/or the micropurchase threshold.

Recommendation 3: Establish controls to confirm approving officials and purchase cardholders review purchases for VA policy compliance and ensure contracting is used when it is in the best interest of the government.

Concur or Non-concur: Concur

Target date for completion: September 30, 2023

Director Comments: To ensure cardholders and Approving Officials comply with VA policy supervisors will incorporate cardholder and AO responsibilities into their employee's performance plan, if not already done so, as was directed by the VISN 4 Deputy Network Director in 2021 and effective Fiscal Year 2022. Additionally, a Medical Center Memorandum shall be established by the healthcare facility outlining purchase card responsibilities and procedures to include disciplinary actions for violations of this memorandum. The Medical Center Memorandum will be signed by the facility director and published through the medical center director's office for dissemination to facility employees.

In order to enhance VA's purchasing authority, Financial Policy for Government Purchase Card for Micro-Purchases, Volume XVI – Chapter 1B, 010503 Strategic Sourcing directs the implementation and utilization of strategic sourcing by Administrations and Staff Offices to ensure their employees obtain proper contracts when procuring goods and services on a regular basis. AOs, A/OPCs, and cardholders must review their purchases and determine when it is in the best interest of the Government to utilize strategic sourcing for particular goods or services.

Each fiscal quarter the Purchase Card Program Manager (Level 3 A/OPC) will continue to generate and disseminate to the facility Associate Director a copy of their station's History of Purchase Card Transactions report. A copy of this report will be provided by the Philadelphia Associate Director to the service line chiefs at the facility. The service line chiefs will review this report with supervisors, Approving Officials, and cardholders among their staff as applicable based on the transactional data from the report. Service line chiefs, cardholders, and Approving Officials will review purchase card spend and identify repetitive orders and potential vendors for contracts in keeping with strategic sourcing initiatives. Each quarter cardholders and their respective Approving Officials shall review the History of Purchase Card Transactions report with the facility's Acquisition Utilization Specialist (AUS) to communicate on-going repetitive orders of goods or services that have been made through commercial (open market) sources using the government purchase card. The facility's Acquisition Utilization Specialist (AUS) will then communicate these findings to Contracting consisting of vendors and purchase card transactions identified for potential contracts on the Philadelphia & NCO4 Contracting Monthly Teleconference (1st Monday 10AM-11AM).

Recommendation 4: Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.

Concur or Non-concur: Concur

Target date for completion: May 30, 2023

Director Comments: The cardholder(s) identified as having exceeded their authorized single purchase limit is to initiate and submit a FORCE package to NCO 04 Contracting. Instructions for generating a ratification package for Unauthorized Commitments can be found in section 1.5., Step 3 of the Ratification SOP.

Finding 3: The Healthcare System Should Ensure Supply Chain Operations Comply with VHA Policy and Inventory Data Are Accurate

Recommendation 5: Ensure the Chief Supply Chain Officer establishes local processes and procedures so that all necessary reports are routinely monitored on the Supply Chain Common Operating Picture, the Generic Inventory Package, or other inventory sites or software systems to ensure performance measures are maintained, as required in the Veterans Health Administration's Directive 1761, *Supply Chain Management Operations*.

Concur or Non-concur: Concur.

Target date for completion:

- Leadership Metric (EX and NX) Review Monthly- February 22, 2023
- NX Quarterly Review w/ VISN- April 27, 2023
- EX Quarterly Review w/ VISN- September 30, 2023

Director Comments: To ensure Supply Chain Compliance, the Logistics EX Supervisor reviews 9 key metrics in SCCOP on a daily basis to include GIP thus ensuring Logistics performance measures are routinely monitored and met. In addition, the Supply Chain leadership team reviews metrics monthly (4th Thursday of every month) in both business areas – Expendables (EX) and Non-Expendables (NX).

Quarterly, the NX team reviews its key metrics with the VISN NX Team. The EX supply chain team is looking to adopt this same protocol with the EX VISN team – TBD.

Recommendation 6: Ensure supply chain managers implement a plan for staff training to increase awareness of internal controls and data reliability issues, such as conversion factor, within the Generic Inventory Package.

Concur or Non-concur: Concur.

Target date for completion: March 10, 2023

Director Comments: Supply Chain leadership team has developed a Service Level Training plan (see attached) along with Service Line Training SOP. Each manager is responsible for executing their business unit specific monthly training plans which are signed and approved by the Deputy CSCO and the CSCO. By executing their respective plans, staff will become more aware of internal controls and the importance of data reliability along with fundamental inventory/supply management. Below is a copy of the Supply Chain Training Plan (V1.0) with the Service SOP (executed 3/10/23) embedded within the document. SCM is in the process of re-establishing and rolling out a robust training plan across all business units.

Recommendation 7: Ensure the Chief of Supply Chain Services provides quarterly physical inventory memoranda “A” classified items to Veterans Integrated Service Network personnel, as required in the Veterans Health Administration’s Directive, 1761, Supply Chain Management Operations.

Concur or Non-concur: Concur.

Target date for completion: June 30, 2023 (Next Inventory - Quarter 3 FY23)

Director Comments: Signed memorandum will be forwarded to VISN CLO and Deputy Network Director.

Recommendation 8: Ensure the Supply Chain Officer Reviews the Facility Item Master File Edit access list of all individuals at the VA medical facility who have permissions to enter or modify data within the item master file each calendar year, as required in the Veterans Health Administration’s Directive 1761, *Supply Chain Management Operations*.

Concur or Non-concur: Concur.

Target date for completion: May 8, 2023

Director Comments: CSCO to review the Facility Item Master File Edit access list and edit permissions as needed at the beginning of each calendar year.

Finding 4: The healthcare system could improve pharmacy efficiency and strengthen oversight controls

Recommendation 9: Develop formalized processes for monitoring and achieving identified efficiency targets and use available pharmacy data to make business decisions.

Concur or Non-concur: Concur

Target Date for Completion: September 30, 2024

Director Comments: The agency agrees. The pharmacy service will develop a process to monitor efficiency targets that will support and inform our decision making in developing goals and monitor our performance against these targets. We will work with the CFO or a designee to ensure our plan is achievable and sustainable.

The pharmacy service will utilize the OPES pharmacy expenditure data as a baseline for pharmacy operational efficiency at the VA Medical Center. As stated, we expect to track costs and identify potential opportunities for improvement. In addition, we will work with our vendor partners to assist in our forecasting and decision making. We plan to compare our cost effectiveness with other VA Medical Centers within the VISN.

Recommendation 10: Establish measures to improve compliance with the VA directive to avoid end-of-year pharmaceutical purchases.

Concur or Non-concur: Concur

Target Date for Completion: July 31, 2024

Director Comments: We will monitor market trends and discrepancies earlier in the fiscal year to secure funding for early product purchase where appropriate. When the market conditions are appropriate, we believe it is in the best interest of our Veterans to secure critical/expensive medications at current market prices. This decision will be based on ongoing meetings and consultation with Chief of Finance. Our guidance and decision will be informed by current market conditions. Should the opportunity exist to purchase critical/expensive medications at lower prices, we believe that we would be able to:

- Eliminate waste and reduce expenses
- Avoid interruption in patient care due to drug shortages and increased product demand. (i.e. oncology products)
- Reduce pharmacy spending for the next fiscal year and allow the agency to fund other priorities for the agency.

We will also identify top 10% of our highest cost medications at the Pharmacy & Therapeutics (P&T) Committee quarterly to ensure we are meeting appropriate par levels to sustain us through the year.

Recommendation 11: Develop a plan to align inventory management practices, such as the use of handheld scanners, bar code labeling, and ABC inventory analysis methodology with VHA policy.

Concur or Non-concur: Concur

Target Date for Completion: June 30, 2023

Director Comments: The pharmacy service will work with our IT, Finance, and our primary vendor to assist in bar coding and inventory analysis. We will operationalize SIMS and utilize the McKesson handheld scanners, bar code labeling, and inventory analysis methodology consistent with VHA policy.

Recommendation 12: Establish processes to ensure compliance with the Veterans Health Administration directive to complete the B09 reconciliation process

Concur or Non-concur: Concur

Target Date for Completion: June 30, 2023

Director Comments: The agency agrees with this recommendation and finding. We concur that B09 reconciliation process will improve efficiency and inform our decision making. Effective immediately, the pharmacy service will submit monthly B09 reconciliation reports to the Fiscal office to correct any discrepancies appropriately. This will be monitored by Service Chiefs of Pharmacy and Finance for review and signatures every month. This process will be monitored on the Pharmacy Dashboard and discussed monthly at pharmacy leadership meetings.

(original signed by)

Karen Flaherty-Oxler, MSN, RN
Medical Center Director
Corporal Michael J Crescenzo VA Medical Center (642-Philadelphia)

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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